REPORT 9

ATASCADERO STATE HOSPITAL

October 18-22, 2010

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

The Court Monitor is responsible only for monitoring and providing an independent evaluation of Atascadero State Hospital's compliance with the Enhancement Plan.

The Court Monitor is not in any way responsible for the services provided at Atascadero State Hospital or for outcomes of these services for any individual resident at the facility during or following the tenure of the Enhancement Plan. Neither the Court Monitor nor his experts are in any way responsible for the administration of the facility, the day-to-day clinical management of the individuals served, clinical outcomes for any individual, staffing, outcomes for staff providing services at the facility or any other aspect of the operations of Atascadero State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

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Acronyms used in Court Monitor reports:

AA	Alcoholics Anonymous
ABA	Applied Behavior Analysis
ACNS	Assistant Coordinator of Nursing Services
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AED	Anti-epilepsy drug
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
A/N/E	Abuse/Neglect/Exploitation
ARNP, BC	Advanced Registered Nurse Practitioner, Board Certified
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
ASL	American Sign Language
A-WRP	Admission Wellness and Recovery Plan
B & B	Bladder and Bowel
BCC	Behavioral Consultation Committee
BFA	Basic first aid
BG	Behavior Guidelines
BMI	Body Mass Index
CA	Clinical Administrator
CAC	Cooperative Advisory Council
CAF	Corrective Action Form
CASAS	Comprehensive Adult Student Assessment Systems
CCA	Clinical Chart Auditing
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CET	Consistent Enduring Team

CEU	Continuing Education Units
CHF	Congestive heart failure
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
CMT	Clinical Management Team
CON	Clinical Oversight Nurse
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment/Court-Ordered Outpatient Treatment
COVR	Classification of Violence Risk
C-PAS	Central Psychological Assessment Services
CPR	Cardio-pulmonary resuscitation
CRG	Council Representative Group
CRIPA	Civil Rights of Institutionalized Persons Act
CSW	Clinical Social Worker
CV	Curriculum vitae (i.e. resumé)
CXR	Chest x-ray
DBT	Dialectical behavioral therapy
DCAT	Developmental and Cognitive Abilities Team
DMH	Department of Mental Health
DOJ	Department of Justice
DPH	Department of Public Health
DPS	Department of Police Services
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DTO	Danger(ousness) to others
DTR	Dietetic Technician, Registered
DTS	Danger(ousness) to self
DUE	Drug Utilization Evaluation
Dx	Diagnosis
EAP	Employee Assistance Program
EKG	Electrocardiogram
EMS	Emergency Medical Service

EMT	Emergency Medical Technician
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms
EPT	Executive Policy Team
ETRC	Enhanced Trigger Review Committee
FDA	Food and Drug Administration
FMLA	Family and Medical Leave Act
FQRP	Forensic Quality Review Panel
FRP	Forensic Review Panel
FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
FTS	Follow Through Staff
GAF	Global Assessment of Functioning [Score]
GIVI	Gastrointestinal viral illness
H&P	History and Physical [Examination]
HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HAU	Hospital Annual Update (training)
HEP	High Efficiency Particulate Air
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HOM	Hospital Oversight and Monitoring
HSS	Health Services Specialist
HTN	Hypertension
IAPS	Integration Assessment: Psychology Section
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility

ICLN	Infection Control Liaison Nurse
ICPT	Infection Control Psych(iatric) Tech(nician)
IDN	Inter-Disciplinary Note
IER	Independent External Review
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LPS	Lanterman-Petris-Short [Act] (re involuntary civil commitment)
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Record
MAS	Medical Ancillary Services
MBS	Modified barium swallow
MDO	Mentally Disordered Offender
MFT	Marriage and Family Therapist
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MOSES	Monitoring of Side Effects Scale
MPPN	Monthly Physician's Progress Note
MRMC	Medical Risk Management Committee
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous; Nurse Administrator
N/A	Not applicable
NAC	North Activity Center

NAMI	National Alliance on Mental Illness
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NEC	Nurse Executive Council
NEO	New Employee Orientation
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NMS	Neuroleptic Malignant Syndrome
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
ORIF	Open Reduction with Internal Fixation [procedure to set bones]
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
PNED	Psychiatric Nurse Education Director

POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	Physical Therapy/Therapist (in Sections D.4 and F.4); Psychiatric Technician (in Sections D.3 and F.3)
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RM	Risk management
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
RR	Readiness Ruler (substance use services assessment tool)
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAAT	Substance Abuse Assessment Team
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation; special investigation/investigator; self-injury
SIB	Self-injurious behavior

SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
SOAP	Subjective, Objective, Assessment, Plan
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
S/P	Status post
S/R	Seclusion/restraint
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
URN	Utilization Review Nurse
VRA	Violence Risk Assessment
VRAT	Vocational Rehabilitation Assessment Tool
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WNL	Within Normal Limits
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP, BC; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Atascadero State Hospital (ASH) from October 18-22, 2010 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

The progress assessment is outlined in this compliance report, which follows the exact sequence of steps as written in the EP. The report covers Sections C through J (Sections A and B contain definitions and principles that do not entail action steps requiring assessment). For each section, a brief narrative summarizes the findings of the entire section in terms of accomplishments and deficiencies. This is followed by details of compliance assessment. The assessment is presented in terms of:

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C.1, C.2, D.1 through D.7, E, F.1 through F.9, G, H, I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

To reiterate, the Court Monitor's task is to assess and report on State facilities' progress to date regarding compliance with provisions of the Enhancement Plan (EP) that was negotiated between the State and the United States Department of Justice. In fulfilling that responsibility, the Court Monitor makes recommendations for changes and enhancements to current practices that he and his team believe can help the facilities achieve compliance in the future. The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

The Court Monitor's recommendations are guided by current generally accepted professional standards of care, current literature and relevant clinical experience. These recommendations are linked to the current stage of the facilities' implementation of the EP. At early stages, many of the recommendations are more focused on process deficiencies. As the facilities make progress in their areas, the recommendations will be directed to clinical outcomes to individuals as required by specific provisions of the EP.

The EP mandates the findings of compliance, but it does not mandate the means by which the facilities' caregivers and administrators execute their responsibilities to individuals or the processes and tactics by which the facilities achieve compliance with the terms of the EP. As noted earlier in this report and in every previous report, a facility is in fact free to use any mechanisms it wishes to implement and achieve compliance with the terms of the EP. The California DMH, however, may impose certain statewide policies, practices and procedures to effect improvements in its hospitals.

B. Methodology

The Court Monitor's evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and facility's internal monitoring and key indicator data. The charts of individuals were selected both randomly and on the basis of adverse outcomes in specific areas. While on site, the evaluators also interviewed administrative, clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes. The data provided by the facility were verified on a random basis to assess accuracy and reliability.

The Court Monitor's compliance findings are a function of independent review and judgment, taking into consideration both quantitative and qualitative factors related to the requirements of the particular EP cell.

The Monitor's quantitative data is typically collected through chart reviews while on site. Sources of qualitative information include: a) chart reviews; b) staff interviews; c) observations of teams, programs and the environment of care; d) assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance and e) assessment of trends and patterns of change rather than single and/or temporary occurrences that are inconsistent with these patterns and trends.

The qualitative assessment may result in compliance findings that vary from a finding that might be expected if based on quantitative data alone.

The Monitor may also evaluate his findings relative to data presented by the facility that results from its internal performance process audits. Such audits serve as quantifiable mechanisms for facility self-assessment of progress on EP requirements. The facility's data is often referenced or included in the body of the report, particularly when it illustrates concordance with the monitor's findings, variance from the monitor's findings, or a pattern over time.

In the ratings of compliance, the Monitor uses a scale of noncompliance, partial compliance and substantial compliance. A rating of noncompliance indicates lack of efforts and progress towards compliance. A rating of partial compliance falls short of the Court

Monitor's threshold of compliance, but indicates progress and efforts towards achieving compliance. A rating of substantial compliance indicates that the facility has met the Monitor's threshold of acceptable progress in implementing specific requirements of the EP.

C. Statistical Reporting

The following statistical abbreviations used in the report are defined as follows:

Abbreviation	Definition
N	Total target population
n	Sample of target population reviewed/monitored
%S	Sample size; sample of target population reviewed/monitored (n) divided by total target population (N) and multiplied by 100
%C	Compliance rate (unless otherwise noted)

D. Findings

This section addresses the following specific areas and processes, some of which are not covered in the body of the compliance report.

1. Key Indicator Data

Key indicators are tracked by each facility as a management tool that can provide an overview of system performance across a number of domains. The key indicators can serve as a "dashboard" for facility leadership in terms of summarizing general performance and assessing trends, but they cannot stand alone as a means of formulating judgment regarding facility performance and practices, including such judgments that are part of EP monitoring. The Court Monitor reviews the key indicators from a statistical point of view, taking into consideration relative clinical significance, but does not conduct independent validation of the data. At times the Court Monitor will comment upon changes that he believes require the facility's attention, but the absence of comment should not be construed as an indication that no attention, investigation or follow-up is necessary. Facility management should continuously review the key indicators to assess trends and patterns and use this data to identify the factors that contribute to changes in facility trends and patterns. Taken as a whole, the key indicators presented by ASH at the time of this review indicate stable performance in a number of domains over the past six months.

2. Monitoring, mentoring and self-evaluation

    a. Regarding the process of self-assessment, this monitor has requested the following:
        i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:
            - Comparison of the mean compliance rates for the main indicator in the entire review period from the current to the previous periods;
            - Comparison of the mean compliance rates for the main indicators and sub-indicators (if they were presented) from the last month of the current review period to the last month of the previous review period;
            - A review of the facility's assessment of barriers towards compliance; and
            - A plan of correction.
        ii. For data demonstrating compliance rates of 90% or more with the main indicators, all facilities should provide comparison of mean compliance rates with the main indicators for the entire review period from the current to the previous periods.
        iii. For data derived from the DMH standardized auditing tools, all facilities should present their data using the same configuration of indicators/sub-indicators for each corresponding requirement of the EP.

    ASH presented its self-assessment data and data comparisons as requested above. The facility has utilized all available DMH standardized auditing tools for all applicable sections of the EP.

    b. The facility's self-assessment data well-organized and internally consistent.
    c. ASH presented process and clinical outcome data regarding its medical services that demonstrated positive outcomes and began to gather and present data regarding process and clinical outcomes for its mental health services.
    d. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care.
    e. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

3. Implementation of the EP

    a. Since the last review, ASH has maintained its progress in the implementation of the EP. This progress is outlined in each corresponding section in the body of the report. As of this tour, the facility appeared to have maintained substantial

compliance with the vast majority of EP requirements. Both the leadership and practitioners of ASH deserve recognition and accolades for their continued commitment to this process and their high standards in serving individuals in their care.

b. The facility must make further progress in the nursing assessments of changes in the physical status of individuals and address a decline in compliance regarding the mental status examinations in both admission and integrated psychiatric assessments.
c. While all requirements must be addressed and satisfied, not all requirements have the same impact on patient safety. This monitor urges all facility and DMH leadership to be on guard against blind spots in terms of the relative importance of functions and tasks and to continuously evaluate the allocation of precious resources and time so that the "must-do" processes that are foundational to patient safety are always prioritized over less urgent, "nice to do" processes. This requires a clear sense of what is vital to the organization's operations.
d. As mentioned previously by this monitor, DMH must continue and finalize, in a timely manner, current efforts to streamline some of the templates for documentation of WRPs and disciplinary assessments and reassessments with input from its clinical staff. The main purpose of this initiative is to achieve a more reasonable balance between time allocated for direct care services and time allocated for documentation and monitoring of the implementation of these services. Leadership and coordination by the facilities' Medical Directors are critical in this endeavor. This monitor will accommodate appropriate modifications in the facilities' self-assessment data that may be necessary as a result of this process and will modify, as needed, the process of on-site chart reviews corresponding to these modifications.
e. During this tour, this monitor observed that some WRPTs at ASH provided excellent examples of streamlined and meaningful WRP review process. These teams addressed the relevant clinical needs of the individuals and maintained a seamless and autonomous clinical flow during the WRP conference while using the strengths in the current WRP format and without being distracted or overly constrained by these formats. These examples should inform current streamlining efforts at DMH.
f. Although much progress has been made, the DMH must continue its efforts to standardize across all hospitals the Administrative Directives that impact these services.
g. A well-functioning PSR Mall that meets the specific needs of the individuals is an important component of the Wellness and Recovery Planning model. ASH has continued its progress towards this goal, as specified in relevant sections in this report.
h. Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions.

4. Staffing

The table below shows the staffing pattern at ASH as of August 25, 2010:

Atascadero State Hospital Vacancy Totals as of 8/25/10				
Identified Clinical Positions	Budgeted Positions 10/11 FY	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	1	1	0	0%
Assistant Director of Dietetics	4	4	0	0%
Audiologist I	0	0	0	0%
Chief Dentist, CF	1	1	0	0%
Chief Physician & Surgeon, CF	1	1	0	0%
Chief Central Program Services	1	1	0	0%
Chief of Police Services & Security	1	1	0	0%
Clinical Dietician	12.3	9.5	2.8	22.76%
Clinical Laboratory Technologist (Safety)	2.5	2.5	0	0%
Clinical Social Worker (Health Facility/S)	58.2	54	4.2	7.22%
Communications Supervisor	1	1	0	0%
Communications Operator	10	8	2	20%
Coordinator of Nursing Services	1	1	0	0%
Coordinator of Volunteer Services	0	0	0	0%
Dental Assistant D/MH & DS	3	3	0	0%
Dentist, D/MH & DS	3	3	0	0%
Dietic Technician (Safety)	5.6	5.6	0	0%
E.E.G. Technician (Psych Tech)	1	1	0	0%
Food Service Technician I	59.5	48	11.5	19.33%
Food Service Technician II	32	30	2	6.25%
Hospital Police Officers	111	105	6	5.41%
Hospital Police Sergeant	15	15	0	0%

Atascadero State Hospital Vacancy Totals as of 8/25/10				
Identified Clinical Positions	Budgeted Positions 10/11 FY	Filled Positions	Vacancies	Vacancy Rate
Hospital Police Lieutenant	4	4	0	0%
Hospital Worker	0	0	0	0%
Health Record Technician	5.3	5	0.3	5.66%
Health Record Technician II (Spec)	6	5	1	16.67%
Health Record Technician II (Supv)	1	0	1	100%
Health Record Technician III	0	0	0	0%
Health Services Specialist (Safety)	26	23	3	11.54%
Institutional Artist Facilitator	1	0	1	100%
Licensed Vocational Nurse (Safety)	2	2	0	0%
Medical Technical Assistant	0	0	0	0%
Medical Transcriber	12	10	2	16.67%
Nurse Instructor	13	12	1	7.69%
Nurse Practioner (Safety)	21	21	0	0%
Nursing Coordinator (Safety)	9	5	4	44.44%
Office Technician	54.5	53	1.5	2.75%
Pathologist	0	0	0	0%
Pharmacist I, D/MH & DS	14	12	2	14.29%
Pharmacist II	1	1	0	0%
Pharmacy Services manager	1	1	0	0%
Pharmacy Technician, D/MH & DS	15	14	1	6.67%
Physician & Surgeon (Safety)	17	17	0	0%
Podiatrist D/MH & DS	0	0	0	0%
Pre-licensed Pharmacist	0	0	0	0%

Atascadero State Hospital Vacancy Totals as of 8/25/10				
Identified Clinical Positions	Budgeted Positions 10/11 FY	Filled Positions	Vacancies	Vacancy Rate
Pre-licensed Psychiatric Technician (Safety)	0	0	0	0%
Pre-Registered Clinical Dietician	0	0	0	0%
Pre-Registered Nurse (D/MD & DS)	0	0	0	0%
Program Assistant (Mental Dis-Safety)	7	5	2	28.57%
Program Consultant (Psychology)	0	0	0	0%
Program Consultant (Rehab. Therapy)	0	0	0	0%
Program Consultant (Social Work)	0	0	0	0%
Program Director (Mental Dis. - Safety)	9	7	2	22.22%
Psychiatric Nursing Education Director	1	1	0	0%
Psychiatric Technician (Safety)	542.1	569.5	-27.4	-5.05%
Psychiatric Technician Trainee (Safety)	48	32.5	15.5	32.29%
Psychiatric Technician Assistant (Safety)	1	1	0	0%
Psychiatric Technician Instructor	0	0	0	0%
Psychologist-HF, Clinical (Safety)	60.5	53.5	7	11.57%
Public Health Nurse I (D/MH &DS)	0	0	0	0%
Public Health Nurse II	3	3	0	0%
Radiologic Technologist	0	0	0	0%
Registered Nurse (Safety)	255	261.8	-6.8	-2.67%
Rehabilitation Therapist S.F., Art-Safety	4	3.5	0.5	12.50%
Rehabilitation Therapist S.F., Dance-Safety	0	0	0	0%
Rehabilitation Therapist S.F., Music-Safety	16	16	0	0%
Rehabilitation Therapist S.F., Occup-Safety	2	2	0	0%
Rehabilitation Therapist S.F., Rec.-Safety	38	32.8	5.2	13.68%

Atascadero State Hospital Vacancy Totals as of 8/25/10				
Identified Clinical Positions	Budgeted Positions 10/11 FY	Filled Positions	Vacancies	Vacancy Rate
Senior Psychiatrist (Specialist)	3	2	1	33.33%
Senior Psychiatrist, CF, (Supervisor)	9	4	5	55.56%
Senior Psychologist, H.F. (Specialist)	10	10	0	0%
Senior Psychologist, C.F. (Supervisor)	11	10	1	9.09%
Senior Psychiatric Technician (Safety)	94	69	25	26.60%
Sr.Radiologic Technologist(Specialist-Safety)	1	1	0	0%
Senior Special Investigator I, D/MH & DS	2	2	0	0%
Senior Vocational Rehab Counselor	1	1	0	0%
Special Investigator I, D/MH & DS	3	0	3	100%
Speech Pathologist I D/MH & DS	0	0	0	0%
Staff Psychiatrist (Safety)	53.6	17.5	36.1	67.35%
Supervising Registered Nurse (Safety)	2	1	1	50%
Teacher-Adult Educ.	10	10	0	0%
Teaching Assistant	7	7	0	0%
Unit Supervisor (Safety)	31	31	0	0%
Vocational Services Instructor	4	4	0	0%
Vocational Rehabilitation Counselor	0	0	0	0%

Key vacancies at this time include senior and staff psychiatrists and special investigators.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;

2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future; and
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. If any hospital maintains substantial or full compliance with any section of the EP for 18 months, the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to provide needed oversight.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Atascadero State Hospital April 18-22, 2011.
2. The Court Monitor's team is scheduled to tour Patton State Hospital December 6-10, 2010 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress:** 1. ASH has maintained substantial compliance with all requirements of Section C.1 and most of the requirements of Section C.2. 2. ASH has maintained effective WRP training and mentoring programs. These programs appear to be sufficient to maintain progress in the implementation of EP requirements in sections C.1 and C.2. 3. ASH has made significant improvement in serving individuals with cognitive limitations by adding three new Mall groups, as well as adding a Peer Mentor project to assist individuals with cognitive limitations. The peer mentors receive training prior to taking on the responsibility. 4. ASH has analyzed violence data at the facility, identified the type of individuals who drive a majority of the violence, and has developed a number of strategies to address violence through staff education and training, and Mall group services. 5. ASH has made significant improvement in organizing, managing, and implementing its enrichment program. The number of activities and the types of activities has increased. The activities are regularly implemented.

1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** Interviewed: 1. Charlie Joslin, Clinical Administrator 2. Donna Nelson, Director, Standards Compliance Department Reviewed: 1. ASH WRP Observation Monitoring summary data (March – August 2010) 2. ASH Clinical Chart Auditing Form summary data (March – August 2010) 3. ASH WRP Team Facilitator Observation Monitoring Form summary data (March – August 2010) 4. ASH data regarding staffing ratios on admissions and long-term units (March – August 2010) Observed: 1. WRPC (Program I, unit 1) for quarterly review of CLW 2. WRPC (Program I, unit 12) for 14-day review of TP 3. WRPC (Program I, unit 13 team A) for 14-day of RLP 4. WRPC (Program I, unit 13) for 14-day review of RR 5. WRPC (Program III, unit 7) for annual review of VV 6. WRPC (Program III, unit 7) for monthly review of SM 7. WRPC (Program V, unit 33) for quarterly review of RSR 8. WRPC (Program V, unit 34) for quarterly review of CMD 9. WRPC (Program VI, unit 18) for quarterly review of RPV 10. WRPC (Program VI, unit 9) for quarterly review of GE 11. WRPC (Program VII, unit 22) for annual review of MJG 12. WRPC (Program VII, unit 26) for monthly review of JWO
C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and	**Current findings on previous recommendations:**

	rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.	**Recommendation 1, April 2010:** Provide a summary outline of any changes in WRP training and mentoring activities provided to the WRPTs during the reporting period. **Findings:** ASH reported no changes to its WRP training program during this review period. On August 10, 2010, the WRP Responsibilities by Discipline was revised to provide further clarity on specific responsibilities. On September 1, 2010 the facility implemented Clinical Management Teams (CMT) in each Program. The membership consists of Program Director, Program Assistant, Nursing Coordinator, Clinical Seniors and Supervisors assigned to the Program, Pprogram Health Service Specialist, and other attendees as requested by the Program Director. As of that date, the facility began phasing out the existing mentors, turning mentoring responsibility over to the Clinical Management Teams. The facility presented results of competency-based training of WRPT members during this review period. The data showed competency rates of more than 90% for all members in all components of the training (WRP Overview, Engagement, Case Formulation, Foci and Objectives, Interventions and Mall Integration, Discharge Planning. The training was provided to all newly hired clinicians and to WRPT members who were referred for refresher training based on need (members were identified based on reviews by the WRP EPPI Committee of all relevant audits). **Recommendation 2, April 2010:** Continue efforts to streamline the process (and content) of WRP review and documentation of this review. **Findings:** During May 2010, ASH developed recommendations to streamline the WRP, disciplinary assessments and audit tools for all disciplines. These recommendations were finalized and forwarded to the HOM team for

review. The HOM team was in the process of working with the identified leads from each discipline to finalize recommendations submitted by each facility and begin implementation.

Recommendation 3, April 2010:
Continue to monitor this requirement:

Findings:
Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WPRCs held each month (March-August 2010):

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.*	100%
2.	*Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for both items.

Other findings:
The monitor and his experts attended 12 WRPCs. The meetings demonstrated that ASH has maintained substantial compliance with EP requirements regarding the process of WRP reviews.

Compliance:
Substantial.

<table>
<tr>
<td></td>
<td></td>
<td>Current recommendations:
1. Provide a summary outline of any changes in WRP training and mentoring activities provided to the WRPTs during the reporting period.
2. Continue efforts to streamline the process (and content) of WRP review and documentation of this review.
3. Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.1.b</td>
<td>Be led by a clinical professional who is involved in the care of the individual.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (March-August 2010):

<table>
<tr><td>1.</td><td>Each team is led by a clinical professional who is involved in the care of the individual.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 100% of the required observations (two WRPC observations per team per month) during the review period:

<table>
<tr><td>1.</td><td>The team psychiatrist was present.</td><td>97%</td></tr>
<tr><td>2.</td><td>The team facilitator encouraged the participation of all disciplines present.</td><td>100%</td></tr>
<tr><td>3.</td><td>The team facilitator ensured the "Present Status"</td><td>100%</td></tr>
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<table>
<tr><td></td><td>section in the case formulation was meaningfully updated.</td><td></td></tr>
<tr><td>4.</td><td>The team facilitator ensured that the interventions were linked to the objectives.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>C.1.c</td>
<td>Function in an interdisciplinary fashion.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH WRP Observation Monitoring Form, ASH reported a mean compliance rate of 100% based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (March-August 2010). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
</table>

C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH WRP Clinical Chart Audit, ASH reported a mean compliance rate of 100% based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (March-August 2010). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.1.e	Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement **Findings:** Using the DMH WRP Observation Monitoring Form, ASH reported a mean compliance rate of 100% based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (March-August 2010). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

		Compliance: Substantial. **Current recommendation**: Continue to monitor this requirement.
C.1.f	Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH WRP Observation Monitoring Form, ASH reported a mean compliance rate of 100% based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (March-August 2010). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.1.g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual

<table>
<tr>
<td></td>
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<td>WRPCs held each month during the review period (March-August 2010):

<table>
<tr><td>5.</td><td>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.1.h</td>
<td>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
ASH presented core WRPT member attendance data based on an average sample of 20% of quarterly and annual WRPCs held during the review period (March-August 2010):

<table>
<tr><th></th><th>Previous review period</th><th>Current review period</th></tr>
<tr><td>Individual</td><td>94%</td><td>94%</td></tr>
<tr><td>Psychiatrist</td><td>97%</td><td>95%</td></tr>
<tr><td>Psychologist</td><td>83%</td><td>83%</td></tr>
<tr><td>Social Worker</td><td>79%</td><td>76%</td></tr>
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<td></td>
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<table>
<tr><th></th><th>Previous review period</th><th>Current review period</th></tr>
<tr><td>Rehabilitation Therapist</td><td>82%</td><td>85%</td></tr>
<tr><td>Registered Nurse</td><td>98%</td><td>98%</td></tr>
<tr><td>Psychiatric Technician</td><td>92%</td><td>88%</td></tr>
</table>
Compliance:
Substantial.
Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>C.1.i</td>
<td>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</td>
<td>
Current findings on previous recommendation:
Recommendation, April 2010:
Continue to monitor this requirement.
Findings:
The facility provided the following data on average case load ratios:
<table>
<tr><th></th><th>Previous review period</th><th>Current review period</th></tr>
<tr><td></td><td colspan="2">Admission Units</td></tr>
<tr><td>MDs</td><td>1:12</td><td>1:15</td></tr>
<tr><td>PhDs</td><td>1:16</td><td>1:13</td></tr>
<tr><td>SWs</td><td>1:14</td><td>1:15</td></tr>
<tr><td>RTs</td><td>1:13</td><td>1:15</td></tr>
<tr><td>RNs</td><td>1:6</td><td>1:8</td></tr>
<tr><td>PTs</td><td>1:3</td><td>1:9</td></tr>
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<table>
<tr><td></td><td>Previous review period</td><td>Current review period</td></tr>
<tr><td></td><td colspan="2">Long-Term Units</td></tr>
<tr><td>MDs</td><td>1:19</td><td>1:16</td></tr>
<tr><td>PhDs</td><td>1:30</td><td>1:19</td></tr>
<tr><td>SWs</td><td>1:27</td><td>1:19</td></tr>
<tr><td>RTs</td><td>1:30</td><td>1:18</td></tr>
<tr><td>RNs</td><td>1:10</td><td>1:12</td></tr>
<tr><td>PTs</td><td>1:5</td><td>1:8</td></tr>
</table>

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>C.1.j</td>
<td>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Same as C.1.a through C.1.f.

Findings:
Same as C.1.a through C.1.f.

Compliance:
Substantial.

Current recommendations:
Same as C.1.a through C.1.f.</td>
</tr>
</table>

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** Interviewed: 1. Adam Brothman, PsyD, Psychologist 2. Brooke Hatcher, Supplemental Activities Coordinator 3. Charlie Joslin, Clinical Administrator 4. Dawn Hartman, Assistant Director of Dietetics 5. Erin Dengate, Assistant Director of Dietetics 6. Heidi Mickel, LCSW, Senior Supervising Social Worker 7. Janet Bouffard, LCSW, Social Work Chief 8. Karen Dubiel, Assistant to the Clinical Administrator 9. Killorin Riddell, PhD, Coordinator Psychology Specialty Services 10. Ladonna Decou, Chief of Rehabilitation 11. Matthew Hennessy, PhD, Mall Director 12. Michael Ostash, LCSW, Senior Supervising Social Worker 13. Mike Hughes, MSRN, Acting WRP Master Trainer 14. Peter Pretkel, PhD, Psychologist 15. Rachelle Rianda, Acting Senior Rehabilitation Therapist 16. Richard Murray, PhD, Senior Supervising Psychologist 17. William Hallum, Substance Abuse Services Reviewed: 1. The charts of the following 112 individuals: AA, AAA, AEC, AJG, AJK, AM, BE, BM, BMC, BU, CA, CB, CC, CD, CH, CL-1, CL-2, CLD, CP, CRC, CV, DMM, DRS, DWH, EA, EC, ECG, ERA, ES, EZ, FAG, FC, GAB, GCJ, GE, GI, GS, HAC, HC, IES, JAD, JB, JBP, JC, JJS, JKC, JL, JP, JW, JWB, KAT, KH-1, KH-2, KRM, KRN, LB, LEB, LG, LHE, LW, MA, MAT, MBC, MC, MDC, ME, MRL, MWT, NC, NG, PDV, PG, PN, PPD, PS, RA, RA-1, RA-2, RA-3, RAL, RC-1, RC-2, RDC, RDW, REA, REM, RF, RG, RJ, RJH, RJS, RLJ, RLP, RMR, RP, RPM, RPV, RS, RSD, RSG, SB, SBH, SC, SDH, SG, SH, SLW, SPH, SRW, TLA, TOJ and VIJ 2. One WRP per WRPT for the following 54 individuals: AEC, AES, AM,

		ARC, AW, BAC, BB, BLB, BP, CO, DAW, EGM, EOO, ET, FXM, GAG, GMB, GMK, GRM, HRM, JAS, JHB, JJN, JMO, JNA, JNS, JV, KW, LJC, MAG, MDM, MJ-1, MJ-2, MRL, MT, MVB, PH, PNC, RA-1, RA-2, RA-3, RAN, RB, RC-1, RC-2, RH, RLS, RMM, SB, SDH, SDP, SSS, TLW and WL 3. Integrated Psychological Assessments on the following four individuals: GI, HAC, LEB, and RA 4. Focused Psychological Assessment – Neuropsychological Evaluation for MBC 5. ASH Substance Abuse Services Data Report July – September 2010 6. Document comparing current and previous review period; hours and types of cognitive remediation groups and summary of process changes. 7. Lesson plans for the following: • Brain Fitness: Basics through Music • Brain Fitness: Basics, for the following three individuals: HAC, MBC and RA • Brain Fitness: Get With It, for the following three individuals: LEB, LG and RS • Brain Fitness: Memory, for individual CP • Brain Fitness: Reasoning, for individual RA 8. ASH WRP Observation Monitoring summary data (March – August 2010) 9. ASH Clinical Chart Auditing Form summary data (March – August 2010) 10. ASH Chart Auditing Form summary data (March – August 2010) 11. ASH Substance Abuse Auditing Form summary data (March – August 2010) 12. Substance Abuse Clinical Outcome summary data (January – September 2010). 13. Substance Abuse Process Outcome summary data (January – October 2010) 14. Substance Abuse Individual Satisfaction Survey summary data

		(March – October 2010) 15. Unit Level Weekly Supplemental Activities List 16. Hospital-Wide Supplemental Activities List 17. Sports, Games, and Tournaments calendar 18. Supplemental Activities Attendance List 19. ASH Newsletter (Volume 2, Issue 3) 20. Family Survey Questionnaire 21. List of individuals meeting trigger threshold during this review period 22. Corrective actions taken on deficiencies cited <u>Observed</u>: 1. WRPC (Program I, unit 13 team A) for 14-day of RLP 2. WRPC (Program VI, unit 18) for quarterly review of RPV 3. WRPC (Program VI, unit 9) for quarterly review of GE 4. Mall Group: Step Up to Health 5. Mall Group: Cognitive Therapy for Psychotic Symptoms 6. Mall Group: Anger Management 7. Mall Group: Star Track, Substance Abuse Recovery group (Preparation Stage) 8. Mall Group: Substance Abuse Recovery Group (Action Stage) 9. Supplemental Activity Coordinators Meeting
C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 20% of the WRPCs held each month during the review period (March-August 2010, reporting a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% since the last review

		period. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** ASH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (March-August 2010). Based on an average sample of 20% of the A-WRPs, the facility reported a mean compliance rate of 100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Other findings:** This monitor reviewed the charts of 10 individuals admitted during the review period (AJK, GAB, KRM, MDC, RDW, REM, RF, RJS, SC and SDH) and found compliance in all cases. **Compliance:** Substantial.

		Current recommendation: Continue to monitor this requirement.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Based on an average sample of20% of the 7-day WRPs, the facility reported a mean compliance rate of 100% with this requirement. The same rate was reported for the previous review period. **Other findings:** This monitor reviewed the charts of 10 individuals admitted during the review period (AJK, GAB, KRM, MDC, RDW, REM, RF, RJS, SC and SDH) and found compliance in all cases. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** The following is a summary of the facility's data:

<table>
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<table>
<tr><th>WRP Review</th><th>Mean sample size</th><th>Mean compliance rate</th></tr>
<tr><td>14-Day</td><td>20%</td><td>100%</td></tr>
<tr><td>Monthly</td><td>20%</td><td>100%</td></tr>
<tr><td>Quarterly</td><td>19%</td><td>100%</td></tr>
<tr><td>Annual</td><td>23%</td><td>96%</td></tr>
</table>

Comparative data indicated that the facility has maintained compliance rates of at least 90% since the last review period.

Other findings:
This monitor reviewed the charts of 10 individuals admitted during the review period (AJK, GAB, KRM, MDC, RDW, REM, RF, RJS, SC and SDH). The review found substantial compliance in nine cases and partial compliance in one (REM).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
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<tr>
<td>C.2.c</td>
<td>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
ASH assessed its compliance using the DMH WRP Clinical Chart Auditing Form. The average sample ranged from 21% to 100% of the relevant population for each sub-indicator during the review period (March-August 2010).</td>
</tr>
</table>

2.	*Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.*	98%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period.

Other findings:
This monitor reviewed the charts of 11 individuals diagnosed with a variety of cognitive disorders as follows:

1. Mild Mental Retardation (RA and GI);
2. Borderline Intellectual Functioning (HAC and RA-2);
3. Vascular Dementia (LEB and CP);
4. Lewy Body Dementia (BMC);
5. Alcohol-Induced Persisting Dementia (SBH);
6. Dementia of the Alzheimer's Disease (LG); and
7. Cognitive Disorder NOS (RS and AAA).

In addition, this monitor reviewed the charts of six individuals diagnosed with seizure disorders (JJS, LEB, MRL, RAL, RJ and RLJ). The reviews found general evidence that ASH has maintained progress in the following areas:

1. Review of seizure activity and cognitive functioning in the Present Status section of the case formulation;
2. Development and review of learning-based objectives and interventions to address the needs of individuals diagnosed with dementing illnesses and seizure disorders;
3. Cognitive assessments/screening tests to determine the level of cognitive functioning and to assist in the diagnosis of cognitive

		impairments; 4. Neuropsychological assessments of individuals with cognitive impairments; 5. Formal and informal cognitive remediation interventions for individuals diagnosed with cognitive disorders; 6. Timely neurological consultations to address changes in the status of individuals with seizure disorders; and 7. Caution in the use of long-term high risk medications (anticholinergic and benzodiazepines) for individuals diagnosed with cognitive impairments. The review found a few deficiencies as follows: 1. The objective statement for an individual with seizure disorder was generic. However, the interventions were specific and aligned with proper learning-based objectives (RLJ). 2. The WRP of an individual diagnosed with cognitive impairment did not consider the diagnosis suggested by the psychologist as a result of a formal cognitive assessment (HAC). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	**Compliance:** Substantial.

<table>
<tr>
<td>C.2.d.i</td>
<td>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</td>
<td>
Current findings on previous recommendations:

Recommendation 1, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (March-August 2010):

<table>
<tr><td>3.</td><td>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period.

The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed, as necessary.

Recommendation 2, April 2010:
Continue efforts to streamline the review and presentation of data in the case formulation.

Findings:
Same as in Recommendation 2 in C.1.a. The DMH is currently in the process of streamlining the WRP to minimize duplication between the WRPs (Present Status section of the Case formulation) and the Psychiatric Progress Notes.
</td>
</tr>
</table>

		Other findings: This monitor reviewed one WRP per WRPT for the following 54 individuals: AEC, AES, AM, ARC, AW, BAC, BB, BLB, BP, CO, DAW, EGM, EOO, ET, FXM, GAG, GMB, GMK, GRM, HRM, JAS, JHB, JJN, JMO, JNA, JNS, JV, KW, LJC, MAG, MDM, MJ-1, MJ-2, MRL, MT, MVB, PH, PNC, RA-1, RA-2, RA-3, RAN, RB, RC-1, RC-2, RH, RLS, RMM, SB, SDH, SDP, SSS, TLW and WL. The review found general evidence that ASH has maintained substantial compliance with the requirements regarding the structure and content of the case formulation. **Current recommendation**: Continue to monitor this requirement.
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	The facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period.
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	The facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period.
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	The facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period.
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	The facility reported a mean compliance rate of 94%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period.

C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	The facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period.
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH WRP Chart Auditing Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (March-August 2010), reporting a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period. **Other findings:** This monitor reviewed the records of 12 individuals receiving Rehabilitation Therapy Services to assess compliance with the requirements of C.2.e. All records were in substantial compliance. This monitor also reviewed the records of nine individuals who had IA:RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments during the review period to assess compliance with the requirements of C.2.e. Eight records were in substantial compliance (AEC, CLD, GCJ, MAT, ME, RC, RPM and TOJ) and one record was not in compliance (JKC).

<table>
<tr><td></td><td></td><td>Finally, this monitor reviewed the records of nine individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>C.2.f</td><td>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</td><td>Please see sub-cells for compliance findings.</td></tr>
<tr><td>C.2.f.i</td><td>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH WRP Chart Auditing Form, ASH assessed its compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (March-August 2010):

<table>
<tr><td>5.</td><td>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of</td><td>99%</td></tr>
</table>
</td></tr>
</table>

				each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.	| Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period: **Other findings:** A review of the charts of six individuals found that all WRPs included adequate formulation of the individual's strengths (AJK, GAB, RDW, REM, RF and SDH). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** The facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period. **Other findings:** A review of the charts of six individuals found substantial compliance in all cases (AJK, GAB, RDW, REM, RF and SDH).

		Compliance: Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** The facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period. **Other findings:** A review of the charts of six individuals found substantial compliance in four cases (AJK, REM, RF and SDH) and partial compliance in two (GAB and RDW). The charts of GAB and RDW included evidence of some objectives that were irrelevant to the needs of the individuals such as naming medications and their doses (RDW) or identifying symptoms that are difficult to manage in the community (GAB). **Compliance:** Partial; improved compared to last review. **Current recommendations**: 1. Streamline the WRPs to ensure that all objectives are relevant to the individual's current needs.

		2. Continue to monitor this requirement.
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** The facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period. **Other findings:** A review of the charts of six individuals found substantial compliance in all cases (AJK, GAB, RDW, REM, RF and SDH). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.f.v	ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** The facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period.

<table>
<tr>
<td></td>
<td></td>
<td>Other findings:
A review of the charts of six individuals found substantial compliance in all cases (AJK, GAB, RDW, REM, RF and SDH).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.2.f.vi</td>
<td>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</td>
<td>Current findings on previous recommendations:

Recommendations 1-3, April 2010:
• Continue to monitor hours of active treatment (scheduled and attended).
• Continue to present data regarding average numbers of scheduled and attended hours (previous period and last month of previous period compared to current period and last month of current period).
• Continue to address factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.

Findings:
ASH presented the following data for the review period (March-August 2010):

<table>
<tr><td></td><td colspan="2">Number of individuals by category</td></tr>
<tr><td></td><td>Mean scheduled hours</td><td>Mean attended hours</td></tr>
<tr><td>N</td><td>1120</td><td>1120</td></tr>
<tr><td>Hours:</td><td></td><td></td></tr>
<tr><td>0-5</td><td>123</td><td>670</td></tr>
<tr><td>6-10</td><td>170</td><td>261</td></tr>
</table>
</td>
</tr>
</table>

11-15	449	152
16-20	378	37

	Previous period	Current period
Hours in last month of period		
Mean scheduled	15	13
Mean attended	6	5

This monitor reviewed the charts of 11 individuals. The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The following table summarizes the monitor's findings:

Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours
BE	11	11.5	1.5
BU	18	14.5	3.5
CD	9	8.5	6.5
ES	16	11.5	5
FC	17	13	0.5
JC	13	11	10
JL	12	11.5	9
LB	17	13	8.5
NC	19	16.5	10
PG	14	17	0.5
SG	15	14	11.5

As the table above indicates, ASH continues to have issues with the lack of alignment between the WRP scheduled hours and MAPP scheduled hours. ASH should find reasons for the lack of alignment and fix the problem. It is difficult to interpret the attended hours given the

		differences between the two schedules, since the attendance might be in error in the MAPP data and/or the individual might not have the correct schedule to attend the appropriate groups. **Compliance:** Partial. **Current recommendations**: 1. Continue to monitor hours of active treatment (scheduled and attended). 2. Continue to present data regarding average numbers of scheduled and attended hours (previous period and last month of previous period compared to current period and last month of current period). 3. Continue to address factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.
C.2.f.vii	maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and	This requirement is not applicable to ASH at this time.
C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on a mean sample of 20% of quarterly and annual WRPs

<table>
<tr>
<td></td>
<td>groups that link directly to the objectives in the individual's WRP and needs.</td>
<td>due during the review period (March-August 2010):

<table>
<tr><td>1.</td><td>Ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</td><td>99%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the charts of six individuals found that all six were provided with the appropriate groups and services for their identified diagnoses, needs and discharge requirements (ECG, ERA, KRN, PDV, RJS and SRW).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement</td>
</tr>
<tr>
<td>C.2.g</td>
<td>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</td>
<td>Please see sub-cells for compliance findings.</td>
</tr>
</table>

C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items. **Other findings:** A review of the charts of six individuals found substantial compliance in all cases (AJK, GAB, RDW, REM, RF and SDH). This monitor also reviewed the records of 10 individuals receiving direct therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its

compliance based on an average sample of 60% of individuals placed in seclusion and/or restraints each month during the review period (March-August 2010), reporting a mean compliance rate of 92%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period.

Other findings:
This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period. The review focused on the documentation in the Present Status section of the circumstances leading to the use of restrictive intervention and treatment provided to avert the use of the interventions. The modification of psychiatric management, as indicated, is addressed in this monitor's findings in D.1.f. The following table outlines the chart reviews:

Individual	Date of seclusion and/or restraint	Date of applicable WRP review
JWB	7/10/10	9/10/10
NG	7/23/10	9/14/10
RSD	8/5/10	9/13/10
LHE	8/5/10	8/20/10
DWH	8/9/10	9/2/10
REA	9/29/10	10/7/10

This review found substantial compliance in all cases.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

C.2.g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (March-August 2010). The facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period. **Other findings:** This monitor assessed the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation). The review found substantial compliance in all charts (AJK, GAB, RDW, REM, RF and SDH). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2010:** • Continue to monitor this requirement. • Ensure that Mall notes are consistently filed in the charts or readily available to the WRPTs for review before or during WRPCs.

		Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (March-August 2010), reporting a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period d. **Other findings:** This monitor's chart reviews found substantial compliance in all charts (AJK, GAB, RDW, REM, RF and SDH). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Substantial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement.

<table>
<tr>
<td></td>
<td></td>
<td>Findings:
Using the DMH WRP Mall Alignment Monitoring Form, ASH assessed its compliance based on an average sample of 20% of quarterly and annual WRPs due each month during the review period (March-August 2010):

<table>
<tr><td>2.</td><td>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of six individuals (ECG, ERA, KRN, PDV, RJS and SRW) found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in five records (ERA, KRN, PDV, RJS and SRW).

Other findings:
This monitor reviewed the records of 12 individuals receiving Rehabilitation Therapy Services to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.

Current recommendation:
Continue to monitor this requirement</td>
</tr>
<tr>
<td>C.2.i.ii</td>
<td>Has documented objectives, measurable outcomes, and standardized methodology</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
ASH did not present data for this requirement</td>
</tr>
</table>

		A review of the records of 12 individuals found that all 12 WRPs contained objectives written in a measurable/observable manner (AA, CA, ECG, ERA, EZ, JB, KRN, MA, PDV, RA, RJS and SRW). A review of the records of 13 individuals found that the objectives in 12 WRPs were directly linked to a relevant focus of hospitalization (AA, CA, ECG, ERA, EZ, JB, KRN, MA, PDV, RA, RJS and SRW); objectives were not so linked in one WRP (MJC). **Current recommendation**: Continue to monitor this requirement
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	**Current findings on previous recommendation:** **Recommendation, April 2010:** See C.2.f.viii. **Findings:** See C.2.f.viii. **Current recommendations**: See C.2.f.viii.
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH WRP Mall Alignment Monitoring Form, ASH assessed its compliance based on an average sample of 20% of Mall group facilitators each month during the review period (March-August 2010):

		15. *The group facilitator utilizes the individual's strengths, preferences, and interests.* — 99% Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. A review of WRPs of 12 individuals found that nine WRPs specified the strengths of the individual in all active interventions reviewed (CA, ECG, ERA, EZ, KRN, MA, PDV, RJS and SRW). The remaining three WRPs either failed to include strengths in all the active interventions reviewed, or the stated strength was not in accordance with the DMH WRP Manual (AA, JB and RA). **Current recommendation**: Continue to monitor this requirement.
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on observation of a mean sample of 20% of quarterly and annual WRPs due each month during the review period (March-August 2010): 3. *The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate.* — 99%

<table>
<tr><td></td><td></td><td>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of WRPs of six individuals found that the individual's vulnerabilities were documented in the case formulation section in all six WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (ECG, ERA, KRN, PDV, RJS and SRW).

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>C.2.i.vi</td><td>is provided in a manner consistent with each individual's cognitive strengths and limitations;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH WRP Mall Observation Monitoring Form, ASH assessed compliance based on an average sample of 3% of the Mall group facilitators each month during the review period (March-August 2010):

<table>
<tr><td>16.</td><td>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of six individuals (ECG, ERA, KRN, PDV, RJS and SRW) found that cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section or as part of a neuropsychological assessment in five cases (ERA, KRN, PDV, RJS and SRW) .

A review of documented cognitive levels and Mall group assignments</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>(STAR, Substance Abuse Recovery group) for 13 individuals (AM, BM, CB, CH, CL, CL-2, EC, JP, JW, JW-2, MC, RC and RG) found that the group assignments were appropriate.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.2.i.vii</td>
<td>Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
The facility presented the following data:

<table>
<tr><th></th><th>March</th><th>April</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Mean</th></tr>
<tr><td>N</td><td>10634</td><td>10654</td><td>10678</td><td>9426</td><td>11139</td><td>10781</td><td>10552</td></tr>
<tr><td>n</td><td>10474</td><td>10360</td><td>10227</td><td>8772</td><td>10568</td><td>10321</td><td>10120</td></tr>
<tr><td>%C</td><td>99</td><td>97</td><td>96</td><td>93</td><td>95</td><td>96</td><td>96</td></tr>
</table>

A review of the charts of 11 individuals found that nine contained progress notes (ECG, GE, KRM, LHE, PDV, PN, RJS, RLP and RPV) and that the notes had been reviewed by the WRPTs. Two did not have the progress notes or did not show evidence that the notes had been reviewed by the WRPTs (RJS and SRW).

Other findings:
This monitor reviewed the records of 12 individuals receiving Rehabilitation Therapy Services to assess compliance with the requirements of C.2.i.vii. All records were in substantial compliance.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
</table>

<table>
<tr>
<td>C.2.i.viii</td>
<td>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
The facility provided the following data:

<table>
<tr><th></th><th>Provided hours</th><th>Attended hours</th></tr>
<tr><td>N</td><td>1120</td><td>1120</td></tr>
<tr><td>0-5</td><td>130</td><td>670</td></tr>
<tr><td>6-10</td><td>195</td><td>261</td></tr>
<tr><td>11-15</td><td>480</td><td>152</td></tr>
<tr><td>16-20</td><td>315</td><td>37</td></tr>
</table>

A review of MAPP data on Mall scheduled and attended hours in the records of 11 individuals found that mean scheduled was 13 hours per week (range of 8.5 – 17 hours) and the mean attended was six hours per week (range of 0.5 – 11.5 hours).

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.2.i.ix</td>
<td>is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;</td>
<td>Current findings on previous recommendations:

Recommendation, April 2010:
If the facility has bed-bound individuals, ensure that these individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status, medical health and physical limitations.

Findings:
There is no data to report for this recommendation. ASH did not have</td>
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</table>

<table>
<tr>
<td></td>
<td></td>
<td>any bed-bound individuals during this review period.

Current recommendation:
If the facility has bed-bound individuals, ensure that these individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status, medical health and physical limitations.</td>
</tr>
<tr>
<td>C.2.i.x</td>
<td>routinely takes place as scheduled;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
ASH presented the following data regarding cancellation of Mall groups:

<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Mean</th></tr>
<tr><td>Groups scheduled</td><td>4562</td><td>5125</td><td>4383</td><td>4023</td><td>1243</td><td>4135</td><td>3912</td></tr>
<tr><td>Groups cancelled</td><td>147</td><td>138</td><td>196</td><td>238</td><td>62</td><td>239</td><td>170</td></tr>
<tr><td>Cancellation rate</td><td>3%</td><td>3%</td><td>5%</td><td>6%</td><td>5%</td><td>6%</td><td>5%</td></tr>
</table>

As shown in the table above, the cancellation rate has been consistently low for each month of this review period. The mean cancellation rate was 8% in the previous review period.

The facility presented the following data regarding Mall group facilitation by discipline:</td>
</tr>
</table>

Average weekly hours provided by discipline		
	Previous review period	Current review period
Psychiatry ACUTE (4)	1.77	1.17
Psychiatry L-T (8)	2.58	2.11
Psychology ACUTE (5)	2.83	2.84
Psychology L-T (10)	5.10	4.59
Social Work ACUTE (5)	3.51	3.52
Social Work L-T (10)	5.38	4.75
Rehab Therapy ACUTE (7)	4.53	3.79
Rehab Therapy L-T (15)	8.72	8.21
Nursing (10)	Not provided	Not provided

Overall, all disciplines have had a reduction in their mean weekly Mall hours provided from the last review period.

Discipline	Hours Scheduled/ Week	Hours Provided/ Week	Percentage of Scheduled Hours Fulfilled
Psychiatry (Adm)	1.65	1.17	71%
Psychiatry (LT)	2.82	2.11	75%
Nurse Practitioner (Adm)	1.81	1.36	75%
Nurse Practitioner (LT)	2.25	1.31	58%
Psychology (Adm)	4.0	2.84	71%
Psychology (LT)	6.42	4.59	71%
Social Work (Adm)	4.73	3.52	74%
Social Work (LT)	6.25	4.75	76%
Rehab Therapy (Adm)	5.17	3.79	73%

Rehab Therapy (LT)	10.64	8.21	77%
Nursing (Adm)	.63	.44	70%
Nursing (LT)	.71	.47	66%
Administration	1.63	1.13	69%

Overall, there has been a reduction in the mean percentage of Mall hours fulfilled for most disciplines. However, as can be seen in the first table, the Mall Director and his staff have been able to work within these limitations to keep the Mall cancellation rate at a low of 5%.

Current recommendation:
Continue to monitor this requirement.

C.2.i.xi

includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and

Current findings on previous recommendation:

Recommendation, April 2010:
Continue to improve on current practice and monitor this requirement.

Findings:
The facility provided the following data regarding enrichment activities:

	Mar	Apr	May	Jun	Jul	Aug	Mean
Hours scheduled	1902	1613	2014	2073	2287	2304	2032
Hours provided	1902	1613	2014	2073	2287	2304	2032
Compliance rate	100%	100%	100%	100%	100%	100%	100%

The facility has made strong improvement in this area. The Supplemental Activity Coordinator has organized the activities both at the central and unit levels. The activities are organized with a common methodology, staff is trained, and attendance is taken. Activity posters and calendars

<table>
<tr><td></td><td></td><td>were posted on the units. Individuals reported they had a variety of activities in sufficient numbers during the weekends.

Current recommendation:
Continue to improve on current practice and monitor this requirement.</td></tr>
<tr><td>C.2.i.xii</td><td>is consistently reinforced by staff on the therapeutic milieu, including living units.</td><td>Current findings on previous recommendations:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the Therapeutic Milieu Observation Monitoring Form, ASH assessed its compliance based on observations of an average sample of 99% of the a.m. and p.m. shifts on units in the facility. The following table summarizes the facility's data:

<table>
<tr><td>1.</td><td>During the 30-min observation, there is more staff in the milieu than in the nursing station.</td><td>100%</td></tr>
<tr><td>2.</td><td>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</td><td>100%</td></tr>
<tr><td>3.</td><td>There is evidence of a unit recognition program.</td><td>97%</td></tr>
<tr><td>4.</td><td>The posted unit rules reflect recovery language and principles.</td><td>100%</td></tr>
<tr><td>5.</td><td>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</td><td>99%</td></tr>
<tr><td>6.</td><td>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</td><td>100%</td></tr>
<tr><td>7.</td><td>Staff is observed actively engaged with the individuals.</td><td>100%</td></tr>
<tr><td>8.</td><td>Staff interacts with individuals in a respectful manner.</td><td>100%</td></tr>
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<table>
<tr><td>9.</td><td>Situations involving privacy occurred and they were properly handled.</td><td>100%</td></tr>
<tr><td>10.</td><td>1If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.

Other findings:
A review of the charts of ten individuals found that all ten contained milieu interventions appropriate to the active intervention (BE, BU, CD, ES, FC, JC, JL, LB, PG and SG).

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>C.2.j</td>
<td>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
The facility presented the following data:

<table>
<tr><td colspan="7">Exercise Groups Offered vs. Needed</td></tr>
<tr><td></td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td></tr>
<tr><td>Number of groups offered</td><td>104</td><td>105</td><td>110</td><td>112</td><td>114</td><td>117</td></tr>
<tr><td>Number of groups needed</td><td>65</td><td>71</td><td>78</td><td>94</td><td>92</td><td>99</td></tr>
<tr><td>Offered/needed</td><td>160%</td><td>148%</td><td>141%</td><td>119%</td><td>124%</td><td>118%</td></tr>
</table>
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<table>
<tr>
<td></td>
<td></td>
<td>The facility also presented the following data:

<table>
<tr><th>BMI Level</th><th>Individuals in each category</th><th>Individuals assigned to Exercise Groups</th><th>Percentage assigned</th></tr>
<tr><td>25 - 30</td><td>536</td><td>458</td><td>85%</td></tr>
<tr><td>31 - 35</td><td>293</td><td>277</td><td>95%</td></tr>
<tr><td>36 - 40</td><td>92</td><td>88</td><td>96%</td></tr>
<tr><td>>40</td><td>65</td><td>63</td><td>97%</td></tr>
</table>

A review of the charts of five individuals with high BMIs (ERA, KRM, MJC, PDV and RJS) found that all five individuals were enrolled in exercise groups.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.2.k</td>
<td>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH C2k Family Therapy Auditing Form, ASH assessed its compliance based on an average sample of 100% of individuals with an assessed need for family therapy services and a signed release for family contact:

<table>
<tr><td>1.</td><td>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and</td><td>100%</td></tr>
</table>
</td>
</tr>
</table>

				documented barriers to family involvement.	
			2.	*Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.*	94%
			3.	*Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.*	100%
		Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items. A review of nine charts of individuals identified as in need of family therapy found that all nine individuals were receiving the services (HC, JP, KH, KH-2, PDV, RA, RP, SB and SH). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement.

	the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	**Findings:** Using the DMH Integration of Medical Conditions in WRP Audit, ASH assessed its compliance based on a 21% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (March-August 2010): 1. *All medical conditions listed on Axis III are included on the Medical Conditions Form.* 100% 2. *The WRP includes each medical condition or diagnoses listed on Axis III.* 100% 3. *There is an appropriate focus statement for each medical condition or diagnosis.* 100% 4. *There is an appropriate objective for each medical condition or diagnosis.* 100% 5. *There are appropriate interventions for each objective.* 98% Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items. A review of the WRPs of 40 individuals (AG, AL, ALH, AMS, ASM, BAW, CCB, CJG, CPR, DJG, DO, DRG, DRO, DVM, EUH, HPA, JD, JKC, JWT, KBA, LEU, MAG, MJA, MM, MPP, OGV, PAJ, RDW, RJS, RJY, RL, RMR, SA, SBH, SM, TDW, TEC, TJO, TOH and VL) found that ASH has continued to make improvements since the last review in the ongoing training and mentoring regarding the development of adequate and appropriate nursing objectives and interventions for Focus 6. The majority of the WRPs reviewed for Focus 6 included appropriate objectives and interventions which comports with ASH's data. ASH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on a sample of 100% of individuals scheduled for but refusing to receive medical procedure(s), including

laboratory tests, during the review months:

6.	*Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.*	92%

Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 38 individuals (AAA, AEB, AJW, AMM, ANM, AV, AVL, AVW, BBS, BP, CJB, CLL, GAB, GDS, GHS, GLS, JCD, JDT, JNS, JPW, JSR, JW, MJ, MT, MWT, PRG, PS, REC, RLC, RLF, RMC, RPM, RPO, RWK, SMW, ST, WD and WJF) found documentation in 28 WRPs addressing the refusal and an open focus with interventions addressing refusals in 11 WRPs. One individual (SMW) noted to be a high risk due to refusals did not have a WRP. These findings do not comport with the facility's data. From discussions with the Standards Compliance Coordinator, the MD/Dentist was rating the risk level of individuals regarding the refusals and those that are rated to be at high risk are to have a WRP implemented by the team. However, regarding the dental refusals reviewed, there was no risk ratings found in the WRPs reviewed for 23 of the records reviewed. Although some of the WRPs had exceptional documentation addressing refusals, the system for addressing refusals was not consistently implemented. ASH's progress report indicated that the system for refusals included the following steps:

- US or NOC shift lead initiates the Daily Appointment Tracking Log by identifying appointments scheduled for the day.
- The AM shift lead assigns a "Follow Through Staff" (FTS) who notifies individuals who have a scheduled appointment or lab.
- The FTS determines if the individual will attend appointment and documents this on the Daily Appointment Tracking log sheet.

		• The FTS reschedules missed appointments and notes the rescheduled date on the log. • The FTS writes an IDN for each refused or missed appointment that included what appointment was missed/refused, the reason, and the date and time of rescheduled appointment. • Daily Appointment Tracking Log information is entered in sick call by the FTS for MD review the following day. The FTS signs the Daily Appointment Tracking Log and places it in the sick call log for the sick call RN. • The MD rates risk of possible adverse outcome regarding the refusal or missed appointment/test in the PPN. The sick call RN then documents the risk in red on tracking log. • The sick call RN signs the Daily Appointment Tracking Log and returns it to the FTS assigned for the day. • The FTS then delivers completed Daily Appointment Tracking Log to the Team Recorder. • The Team Recorder enters all missed and refused appointments into the Task Tracker and notifies the RN Sponsor via email when the refusal information has been entered into the task tracker. The Team Recorder then signs the Daily Appointment Tracking Log and returns it to the US. • The US/Designee ensures that all steps on Daily Appointment Tracking Log have been completed and signs the log. The US will then fax the completed and signed log to the Nursing Coordinator. The US will retain the Daily Appointment Tracking Log for three months. • RN Sponsor is responsible for ensuring that the refusal is addressed in the individual's next WRP. • The Nursing Coordinator ensures that appropriate Refusal Documentation is entered into the WRP by completing a 10% real time review of WRP's prior to finalization, and a 10% spot check of finalized WRP's. • The Nursing Coordinators will notify CNS and RN Mentor if an RN is identified as requiring mentoring in regards to the quality of refusal

		documentation. This includes narrative in Risk Section and objectives and interventions as needed. At the time of the review, there were no formal policies or procedures in place addressing refusals. The facility needs to formalize this process into a written policy/procedure to ensure consistency in addressing refusals across disciplines. **Compliance:** Partial, due to issues related to refusals. **Current recommendations:** 1. Continue efforts aimed at developing a facility-wide system addressing and tracking non-adherence issues. 2. Continue strategies to ensure that WRPs addressing refusals are individualized. 3. Formalize the process for addressing dental refusals into a written policy/procedure to ensure consistency. 4. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of Section C.2.m are not applicable because ASH does not serve children and adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	

<table>
<tr>
<td>C.2.n</td>
<td>Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Same as in C.2.o.

Findings:
Same as in C.2.o.

Compliance:
Substantial.

Current recommendations:
Same as in C.2.o.</td>
</tr>
<tr>
<td>C.2.o</td>
<td>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</td>
<td>Current findings on previous recommendations:

Recommendation 1, April 2010:
Continue to provide summary of process and clinical outcome data regarding delivery of substance use services.

Findings:
The following is a summary of ASH's process outcome data:

<table>
<tr><th>Process Outcomes</th><th>Jan to March 2010</th><th>April to June 2010</th><th>July to Sept 2010</th></tr>
<tr><td>Individuals with Substance Abuse Dx</td><td>786</td><td>No data</td><td>906</td></tr>
<tr><td>Individuals referred for:</td><td>534</td><td>726</td><td>619</td></tr>
<tr><td>o SAS treatment</td><td>242</td><td>357</td><td>276</td></tr>
<tr><td>o AA groups</td><td>148</td><td>184</td><td>172</td></tr>
<tr><td>o NA groups</td><td>144</td><td>185</td><td>171</td></tr>
<tr><td>Individuals screened by SAS</td><td>228</td><td>300</td><td>276</td></tr>
</table>
</td>
</tr>
</table>

Hours of SAS treatment offered per week	101.5	107.5	95.5
SAS sessions scheduled	814	885	661
%SAS sessions held	99%	100%	100%
Individuals enrolled in SAS treatment	725	752	777
Individuals enrolled in AA/NA	673	713	701
Individuals on wait list	14	19	0
Hours of staff training provided	4	1	0
Number of staff trained	7	3	0
Number of staff monitored for fidelity (re implementation of SAS curriculum)	7	1	7

ASH also evaluated the outcome of the SAR services provided this review period. The table below summarizes the data:

Clinical Outcomes	Jan to March 2010	April to June 2010	July to Sept 2010
N=Number enrolled 1st day of quarter	609	622	600
Advanced at least one stage of change or sustained in maintenance	257 (42%)	232 (37%)	268 (45%)
Refused treatment or regressed at least one stage of change	58 (10%)	55 (9%)	15 (2%)
Did not advance in stage of change	196 (32%)	231 (37%)	243 (14%)

Out to Court/Other/ Discharged	98 (16%)	104 (17%)	74 (12%)
Pre/Post Test-Increase Mean	17%pts	17%pts	22%pts

During this review period, ASH changed the facilitators of all pre-contemplative substance use treatment groups from Program staff to Substance Abuse services staff. The facility reported that this change has resulted in more than 100% increase in the number of individuals who advanced from the pre-contemplative stage of change to more advanced stages.

The facility's consumer satisfaction surveys summary data is as follows:

Consumer Satisfaction Survey	Mar-May 2010	June-Aug 2010	Sep-Oct 2010
Learned New Skills			
• Agree	91%	82%	90%
• Disagree	9%	18%	10%
Group was helpful			
• Agree	91%	90%	94%
• Disagree	9%	10%	6%
Understood Information			
• Agree	94%	95%	93%
• Disagree	6%	5%	7%
Group Leader Respectful			
• Agree	94%	94%	96%
• Disagree	6%	6%	4%

Recommendation 2, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Substance Abuse Auditing Form, ASH assessed its compliance with this requirement based on an average sample of 22% of individuals with a current diagnosis of substance abuse (March-August 2010):

1.	*Substance abuse is integrated into the case formulation and discussed in the present status.*	100%
2.	*There is an appropriate focus statement listed under Focus 5.*	100%
3.	*There is at least one objective related to the individual's stage of change.*	100%
4.	*There are interventions that are appropriately linked to the active objective(s).*	98%
5.	*The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.*	100%
6.	*The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.*	97%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% since the previous review period for all items.

Other findings:
Same as in C.2.f.iv.

Compliance:
Substantial.

Current recommendations:
1. Continue to provide summaries of process and clinical outcome data regarding delivery of substance use services.

<table>
<tr><td></td><td></td><td>2. Continue to monitor this requirement.</td></tr>
<tr><td>C.2.p</td><td>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Mall Facilitator Observation Monitoring Form. ASH assessed its compliance based on an average sample of 3% of the clinical facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (March-August 2010):

<table>
<tr><th></th><th></th><th>Previous review period</th><th>Current review period</th></tr>
<tr><td>1.</td><td>Instructional skills</td><td>100%</td><td>99%</td></tr>
<tr><td>2.</td><td>Course structure</td><td>96%</td><td>98%</td></tr>
<tr><td>3.</td><td>Instructional techniques</td><td>100%</td><td>99%</td></tr>
<tr><td>4.</td><td>Learning process</td><td>100%</td><td>100%</td></tr>
</table>

Using the DMH Mall Facilitator Observation Monitoring Form ASH assessed compliance from observation of a 3% sample of all facilitators during the review months (March-August 2010):

<table>
<tr><td>1.</td><td>The session starts and ends within 5 minutes of the designated starting and ending time.</td><td>98%</td></tr>
<tr><td>2.</td><td>The facilitator greets participants to begin the session.</td><td>99%</td></tr>
<tr><td>3.</td><td>The facilitator reviews work from the prior session.</td><td>94%</td></tr>
<tr><td>4.</td><td>The facilitator introduces the day's topic and goals.</td><td>97%</td></tr>
<tr><td>5.</td><td>The facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</td><td>100%</td></tr>
<tr><td>6.</td><td>The facilitator makes an attempt to engage each participant during the group.</td><td>100%</td></tr>
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<table>
<tr><td>7.</td><td>The facilitator attempts to keep all participants "on task" during the session.</td><td>100%</td></tr>
<tr><td>8.</td><td>The facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</td><td>100%</td></tr>
<tr><td>9.</td><td>The facilitator attempts to test the participants understanding.</td><td>100%</td></tr>
<tr><td>10.</td><td>The facilitator presents information in a manner appropriate to the functioning level of the participants.</td><td>98%</td></tr>
<tr><td>11.</td><td>The facilitator summarizes the work done in the session.</td><td>95%</td></tr>
<tr><td>12.</td><td>The facilitator/co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</td><td>100%</td></tr>
<tr><td>13.</td><td>The room is arranged in a way that is as conducive to learning as possible.</td><td>98%</td></tr>
<tr><td>14.</td><td>Lesson plan is available and followed.</td><td>96%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>C.2.q</td>
<td>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Provide data regarding the number of SAR providers/co-providers and the number of certified providers/co-providers.</td>
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Findings:
ASH presented the following data regarding the certification of Substance Abuse facilitators as of July 2010:

<table>
<tr><td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td><td>12</td></tr>
<tr><td>Number of certified SAR providers/co-providers</td><td>6</td></tr>
<tr><td>Percentage of SAR providers/co-providers who are certified</td><td>50%</td></tr>
</table>

ASH should strive to ensure that all SAR providers are certified.

This monitor reviewed charts of 12 individuals diagnosed with Substance Abuse. All 12 individuals had been enrolled in one or more Substance Abuse Recovery and/or related Mall groups (AM, BM, CB, CH, CL, CL-2, EC, JP, JW, MC, RC and RG).

Compliance:
Substantial.

Current recommendation:
Continue to provide data regarding the number and certification of SAR providers/co-providers and seek to increase the number of certified providers/co-providers.
</td>
</tr>
<tr>
<td>C.2.r</td>
<td>Transportation and staffing issues do not preclude individuals from attending appointments.</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
The facility provided the following data on scheduled and cancelled appointments:
</td>
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</table>

Missed Appointments Monitoring – Outside facility Medical service					
	Appointments		Reasons for Cancellation		
	Scheduled	Cancelled	Staffing	Transpor-tation	Other
Mar 10	136	0	N/A	N/A	N/A
Apr 10	170	0	N/A	N/A	N/A
May 10	141	0	N/A	N/A	N/A
Jun 10	144	0	N/A	N/A	N/A
Jul 10	159	0	N/A	N/A	N/A
Aug 10	155	1	0	x	N/A
Total	905	1	0	1	N/A

As the table above shows, only one outside Medical Service appointment was cancelled and the one cancellation was due to a transportation issue. According to the facility, transportation was not available on that particular day and time due to an emergency.

Missed Appointments Monitoring: In-facility Medical Service					
	Appointments		Reasons for Cancellation		
	Scheduled	Cancelled	Staffing	Transpor-tation	Other
Mar 10	882	191	3	0	188
Apr 10	662	137	0	0	137

<table>
<tr>
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<table>
<tr><td>May 10</td><td>645</td><td>146</td><td>3</td><td>0</td><td>143</td></tr>
<tr><td>Jun 10</td><td>669</td><td>126</td><td>0</td><td>0</td><td>126</td></tr>
<tr><td>Jul 10</td><td>321</td><td>115</td><td>0</td><td>0</td><td>115</td></tr>
<tr><td>Aug 10</td><td>702</td><td>273</td><td>0</td><td>0</td><td>273</td></tr>
<tr><td>Total</td><td>3881</td><td>988</td><td>6</td><td>0</td><td></td></tr>
</table>

As the table above shows, nearly 25% of the scheduled in-facility Medical Services were cancelled. Six of the 988 cancellations were due to staffing issues, none were due to transportation issues, and the remaining cancellations (982 cancellations) were primarily due to refusals (573), and missed appointments (409). ASH should conduct an assessment as to the reasons for refusals and missed appointments and address them through reason-specific interventions.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>C.2.s</td>
<td>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
See C.2.i.vi.

Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its</td>
</tr>
</table>

	professional standards of care.	compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (March-August 2010): 10. *Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.* — 100% Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** The facility did not provide data on the numbers of individuals in need of cognitive remediation groups. A review of the WRPs for six individuals found that all six WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (DRM, ECG, KRN, PDV, RJS and SRW). ASH has initiated a number of projects to address the needs of individuals with cognitive limitations. Two such projects include three new Mall groups established by the DCAT (Talk It Out, Health Body Healthy Mind, and Reminiscence: A Positive View of My Life) for those in the "supported" level of cognitive functioning, and the Mentor Project that involves peers accompanying cognitively challenged peers to Mall groups. The peer mentors also spend an hour a week conducting activities. The peer mentors receive a four-hour training on

<table>
<tr><td></td><td></td><td>understanding people with cognitive limitations and are given a manual for further understanding of cognitive issues.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>C.2.t</td><td>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (March-August 2010):

<table>
<tr><td>11.</td><td>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)</td><td>98%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the WRPs for six individuals found that all six WRPs met the elements of this requirement (BE, BSB, CO, CPJ, LHE and NC). In a number of cases, the WRPTs had indicated the reasons for not making changes when an objective had not been met for more than a few months</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>(reasons include absence of Mall notes to make decisions, objective partially met, or individual was non-adherent to the groups and the team continues to encourage or reduce/change the groups).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.2.u</td>
<td>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, April 2010:
• Provide data regarding this requirement (Introduction to Wellness and Recovery for newly admitted individuals).
• Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.

Findings:
ASH presented the following data showing the number of individuals needing WRP education and the number currently receiving these services, as well as the data obtained for the previous review periods.

<table>
<tr><td colspan="5">Individuals in need of WRP Education
during the current and previous three Mall terms</td></tr>
<tr><td></td><td>Oct-Dec 2009</td><td>Jan-Mar 2010</td><td>Apr-Jun 2010</td><td>Jul-Sep 2010</td></tr>
<tr><td>With identified need</td><td>505</td><td>501</td><td>437</td><td>445</td></tr>
<tr><td>Receiving service</td><td>249</td><td>298</td><td>200</td><td>243</td></tr>
<tr><td>% receiving service</td><td>49%</td><td>59%</td><td>46%</td><td>55%</td></tr>
</table>
</td>
</tr>
</table>

		As the table above shows, ASH provides between the WRP education to between 49% and 55% of those needing the services. ASH did not present data regarding the numbers of Introduction to Wellness and Recovery Groups offered, sessions scheduled and attended, and individuals scheduled and attending for the review period. This monitor reviewed records of 13 individuals (BE, CD, ECG, ERA, JC, KH, KRN, LB, NC, PDV, PG, SG and SRW). All 13 individuals were enrolled in a Wellness and Recovery Groups. **Compliance:** Partial. **Current recommendation**: Provide data regarding this requirement (Introduction to Wellness and Recovery for newly admitted individuals). Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.
C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2010:** • Provide data regarding the number of groups scheduled and the percentage held compared to the previous review period. • Based on the implementation of tools designed to assess the need for medication education groups, provide data on the number of individuals with assessed need, number enrolled in medication education groups and percentage that successfully completed groups compared to the previous review period.

Findings:
The facility' data are summarized as follows:

Medication Education Groups Provided March to August 2010	
Sessions scheduled	295
Sessions provided	255
%C	86%

The data showed that ASH has increased the number of medication education groups scheduled and held since the previous review period. The percentage of scheduled groups that were held was 88% in the previous review period.

Individuals Needing and Provided Medication Education Groups			
	Jan–March 2010	Apr-June 2010	July-Sep 2010
# of individuals needing service	681	699	658
# of individuals scheduled for service	681	696	656
# of individuals receiving service	454	426	496

Compliance:
Substantial.

Current recommendations:
1. Provide data regarding the number of groups scheduled and the percentage held compared to the previous review period.
2. Provide data regarding the number of individuals in need for medication education, the number scheduled and the number receiving

<table>
<tr><td></td><td></td><td>this education.</td></tr>
<tr><td>C.2.w</td><td>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</td><td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor and provide data on all the elements for this requirement.

Findings:
The table below showing the mean census for the previous and current review periods (N), and the mean number of individuals meeting the non-adherence criteria is a summary of the facility's data:

<table>
<tr><td></td><td>September 2009 – February 2010</td><td>March – August 2010</td></tr>
<tr><td>N</td><td>1017</td><td>1071</td></tr>
<tr><td>n</td><td>164</td><td>123</td></tr>
</table>

The table above showing the non-adherence data for this review period is based on the newly revised trigger threshold. The new criterion calls for a minimum of 14 days at ASH and a zero attendance for a month to PSR Mall services for consideration as non-adherence.

The facility presented the following set of data on Narrative Restructuring Therapy:

<table>
<tr><td colspan="9">NARRATIVE RESTRUCTURING THERAPY
RATING SCALE DATA</td></tr>
<tr><td rowspan="2">Individual</td><td colspan="2" rowspan="2">Hope Scale Scores</td><td colspan="2" rowspan="2">Mindfulness Attention Awareness Scale Scores</td><td colspan="2" rowspan="2">URICA Indiv. Self Assessment</td><td colspan="2" rowspan="2">URICA Staff Assessment</td></tr>
<tr></tr>
<tr><td>Pre-</td><td>With</td><td>Pre-</td><td>With</td><td>Pre-</td><td>With</td><td>Pre</td><td>With</td></tr>
</table>
</td></tr>
</table>

	NRT	NRT	NRT	NRT	NRT	NRT	NRT	NRT
HA	25	24	2.6	3.1	10	9.4	6.4	11.3
DC	32	30	4.2	4.2	1.3	3.0	8.4	11
PF	26	26	3.9	3.9	7.3	7.3	8	8
YG	25	24	4	4.5	8.6	8.1	10.7	6.7
DG	21	17	4.3	3.8	11.7	11	6.9	6.4
GG	11	11	5.3	5.3	8.7	8.7	3.7	3.7
RH	16	16	2.9	2.9	10	10	9.3	9.3
DH	22	22	2.6	2.6	10	10	9.3	9.3
JL	23	23	4.4	3.7	9.0	8.9	8.7	6
RM	26	26	2.8	2.8	9	9	7.1	7.1
LM	23	18	5.3	3.7	12.1	11	7.3	6.9
DN	22	24	3.5	3.6	13	9.9	9.9	10.1
KR	17	18	1.8	2.7	6	6.1	7	9.9
PR	32	32	5.7	5.9	11.1	9.4	9.7	6.4
JV	19	19	3.5	3.5	8.7	8.7	8	8

The table above shows outcome scores for individuals participating in NRT. It appears that most individuals did not make much improvement in their Hope scale scores, mindfulness, or the URICA self assessment. This is strongly reflected in the URICA staff assessment. There could be many factors for this. Therapists might want to identify factors contributing to progress/improvement or lack thereof (for example, cognition, attendance, mental illness, etc.).

Compliance:
Substantial.

Current recommendation:
Continue to monitor and provide data on all the elements for this requirement.

D. Integrated Assessments		
D	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** 1. ASH has maintained substantial compliance with almost all the requirements in section D.1. The facility must promptly address the decline in compliance with the requirement regarding the admission psychiatric assessments. 2. ASH has made further progress in its medical education programs on-site. **Summary of Progress on Psychological Assessments:** Due to a misunderstanding, it was believed at the time of the tour that monitoring for this section had been turned over to the DMH's HOM team and therefore no chart reviews or interviews were conducted. The facility's internal audit data have been summarized in this section and conditional compliance ratings have been assigned based on the facility's data and its performance during the previous two tours. Monitoring of this section by the court monitoring team will resume in April 2011. **Summary of Progress on Nursing Assessments:** 1. ASH maintained substantial compliance with the requirements of Section D.3. 2. The quality of the Nursing Admission and Integrated Assessments at ASH remains exceptional. **Summary of Progress on Rehabilitation Therapy Assessments:** ASH has maintained substantial compliance with the requirements of Section D.4, and should continue to enhance and improve current practice. **Summary of Progress on Nutrition Assessments:** ASH has maintained substantial compliance with all requirements of Section D.5 with the exception of the sub-item of timeliness of lower-acuity assessments (D.5.f, g, and j.ii.).

		Summary of Progress on Social History Assessments: ASH has maintained substantial compliance with the requirements of Section D.6. **Summary of Progress on Court Assessments:** ASH has maintained substantial compliance with the requirements of Section D.7 for eighteen months (four consecutive tours). As a result, the Court Monitor's evaluation of this section will cease per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.

1. Psychiatric Assessments and Diagnoses		
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** Interviewed: 1. Jean Dansereau, MD, Staff Psychiatrist 2. Joshua Deane, MD, Acting Chief of Psychiatry 3. Veronica Quezada, MD, Staff Psychiatrist Reviewed: 1. The charts of the following 28 individuals: AAA, AJK, BG, DWH, GAB, GC, JD, JWB, KM, KRM, LHE, MDC, MDM, MK, NG, NG-2, RDW, REA, REM, RF, RJS, RSD, SC, SDH, SDP, SM, TE and TS 2. Monthly Psychiatric Progress Note for the following 47 individuals: AB, AJH, AM, BE, CH, CRC, CU, DB, DB-2, DL, DLA, EM, FC, HMH, JA, JB, JB-2, JB-3, JF, JP, JT, KA, KC, KW, LA, LC, MB, MJ, ML, MM, MP, MT, MWM, PA, RC, RC-2, RDC, REA, RR, RS, RW, SDH, SL, SM, SS, TH, and WG 3. ASH Admission Psychiatric Assessment Audit summary data (March – August 2010) 4. ASH Integrated Psychiatric Assessment Audit summary data (March – August 2010) 5. ASH Monthly PPN Audit summary data (March – August 2010) 6. ASH Weekly Physician Progress Note Audit summary data (March – August 2010) 7. ASH Medical Initial Admission Assessment Audit summary data (March – August 2010) 8. ASH Physician Inter-Unit Transfer Note Audit summary data (March – August 2010)
D.1.a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement.

	diagnoses.	**Findings:** ASH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for this review period (March-August 2010). The average samples were 47% of admission assessments, 45% of integrated assessments and 23% of monthly notes on individuals who have been hospitalized for more than 90 days. The compliance rates were reported at 100% for all the indicators in the admission and integrated psychiatric assessments. The rates ranged from 98% to 100% for the indicators in the monthly psychiatric progress notes. These indicators were unchanged from the previous report. Comparative data indicated that the facility has maintained compliance rates at greater than 90% since the last review. **Other findings:** See this monitor's findings in D.1.c and D.1.f. **Compliance:** Substantial. **Current recommendation:** Continue to monitor this requirement.
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to provide data regarding average number of direct care and

<table>
<tr>
<td></td>
<td>Accreditation Counsel for Graduate Medical Education accreditation program, and</td>
<td>supervisory FTE psychiatric positions (filled) and number of board-certified and Board-eligible psychiatrists, with comparisons to the last review period.

Findings:
The facility's report on the number and type of positions is summarized below:

<table>
<tr><th>FTE Psychiatric positions (filled)</th><th>Previous Period</th><th>Current Period</th></tr>
<tr><td>Direct care</td><td>54.6</td><td>60.85</td></tr>
<tr><td>Supervisory</td><td>71 (including second positions)</td><td>76.79 (including second positions)</td></tr>
<tr><td>Board-certified</td><td>46</td><td>51</td></tr>
<tr><td>Board-eligible</td><td>25</td><td>23</td></tr>
</table>

Compliance:
Substantial.

Current recommendation:
Continue to provide data regarding average number of direct care and supervisory FTE psychiatric positions (filled) and number of board-certified and Board-eligible psychiatrists, with comparisons to the last review period.</td>
</tr>
<tr>
<td>D.1.b.ii</td>
<td>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</td>
<td>Current findings on previous recommendations:

Recommendation 1, April 2010:
Continue current practice.

Findings:
ASH has continued to use the previously described Psychiatric Physician</td>
</tr>
</table>

		Quality Performance Profile as part of the privileging at initial appointment and the reprivileging for continued appointment. **Recommendation 2, April 2010:** Provide summary of any corrective actions to address group and/or practitioner trends/patterns. **Findings:** ASH reported that specific practitioner corrective measures are addressed though the Progressive Discipline process as per hospital policy. **Compliance:** Substantial. **Current recommendations**: 1. Provide information regarding the number and percentage of all psychiatrists at the facility who have been reprivileged for continued appointment using information from the practitioner quality profile (as one of the tools for reprivileging). 2. Provide summary of any corrective actions to address group and/or practitioner trends/patterns.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Admission Medical Assessment Monitoring Form, ASH

		assessed its compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 100% of admissions each month during the review period (March-August 2010). The facility reported a compliance rate of 100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Other findings:** This monitor reviewed the charts of 10 individuals who were admitted during the review period (AJK, GAB, KRM, MDC, RDW, REM, RF, RJS, SC and SDH). The review found compliance in all cases. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
D.1.c.i.1	a review of systems;	99%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.2	medical history;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.3	physical examination;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.4	diagnostic impressions; and	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.5	management of acute medical conditions	97%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. .

D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Admission Psychiatric Assessment Audit, ASH assessed its compliance based on an average sample of 47% of admissions each month during the review period (March-August 2010). Mean compliance remained at 100% since the last review. The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c .ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate. **Other findings:** This monitor reviewed the charts of 10 individuals who were admitted during the review period (AJK, GAB, KRM, MDC, RDW, REM, RF, RJS, SC and SDH). The review found substantial compliance in three charts (GAB, MDC and RJS) and partial compliance in seven (AJK, KRM, RDW, REM, RF, SC and SDH). The main deficiency was the lack of specific information regarding abnormalities of the individual's thought content. This information is an essential component of an adequate mental status examination. **Compliance:** Partial. **Current recommendations:** 1. Implement corrective action to ensure that the admission mental status examinations include specific information regarding abnormalities of thought content. 2. Continue to monitor this requirement and ensure accuracy of self-

		assessment data regarding the content of the mental status examination.
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.2	complete mental status examination;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. As mentioned above, findings by this monitor contradicted this data.
D.1.c.ii.3	admission diagnoses;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.4	completed AIMS;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.5	laboratory tests ordered;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.6	consultations ordered; and	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.7	plan of care.	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Integrated Assessment Psychiatry Section Audit, ASH assessed its compliance based on an average sample of45% of Integrated

		Assessments due each month during the review period (March-August 2010). The mean compliance rate was 97%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate. **Other findings:** This monitor reviewed the charts of 10 individuals who were admitted during the review period (AJK, GAB, KRM, MDC, RDW, REM, RF, RJS, SC and SDH). The review found substantial compliance in eight charts (AJK, MDC, RDW, RF, RJS, REM, GAB and SDH) and partial compliance in two (KRM and SC). The assessments in the charts of KRM and SC did not include specific information regarding abnormalities in the individual's thought content. **Compliance:** Substantial. **Current recommendations**: 1. Continue to monitor this requirement. 2. Ensure that the mental status examinations include specific information regarding abnormalities of thought content.
D.1.c.iii.1	psychiatric history, including a review of present and past history;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii.2	psychosocial history;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii.	mental status examination;	100%. Comparative data indicated that the facility maintained a

3		compliance rate of at least 90% from the previous review period.
D.1.c.iii.4	strengths;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii.5	psychiatric risk factors;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii.6	diagnostic formulation;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii.7	differential diagnosis;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii.8	current psychiatric diagnoses;	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii.9	psychopharmacology treatment plan; and	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii.10	management of identified risks.	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Current findings on previous recommendations:** **Recommendation 1, April 2010:** Continue to provide documentation of continuing medical education to psychiatry staff. Provide data regarding the date and title of each program, the instructors with their academic affiliation, if applicable and the physicians who have received training.

Findings:

The following table outlines the educational activities that were provided at ASH during this review period. The table combines neuropsychological/neuropsychiatric disorders and other topics that were relevant to EP requirements in this and other sections (forensic topics are addressed in Section D.7).

Date	Title	Speaker/ affiliations	MD Attendees
3/2/10	ADR: Constipation Requires Admission To Unit 1	S. Mohaupt, MD, ASH	21
3/16/10	DUE: SSRI and DUE: Metabolic Syndrome	S. Mohaupt, MD, ASH	27
3/11/10	Substance Use Disorders	C. Duke, PsyD, ASH	1
3/18/10	Cerebral Vasculature	C. Mathiesen, PsyD, ASH	0
3/25/10	Neuropsychology of HIV	K. Wild, PhD, ASH	0
4/1/10	Violence Risk Assessment Training	H. Richards, PhD, University of Washington	1
4/6/10	Medication Variance: Unclear Order And Chain Of Events	S. Mohaupt, MD, ASH	33
4/8/10	Emotional Disorders	M. Ono, PhD, ASH	1
4/13/10	ADR Data Review Of Trends Over The Last Year	S. Mohaupt, MD, ASH	34
5/4/10	ADR: Six Months Of Data: Synopsis Of Psychopharmacology	S. Mohaupt, MD, ASH	23

			Data		
		5/11/10	DUE: Polypharmacy and Drug Utilization	S. Mohaupt, MD, ASH	23
		5/13/10	Pediatric Head Injury	K. Wild, PhD, ASH	0
		5/18/10	Radiology	D. Winningham, MD, ASH	28
		5/20/10	Neuroanatomy	L. Bolin, PhD, ASH	0
		5/27/10	Correlates of Handedness	C. Duke, PsyD, ASH	0
		6/1/10	ADR	S. Mohaupt, MD, ASH	17
		6/3/10	Neuropsych Theories & Techniques	C. Mathiesen, PsyD, ASH	0
		6/9/10	Psychosis Due to Brain Injury	K. Wild, PhD, ASH	0
		6/15/10	Strategies to Promote Sleep	M. Steed M.D, MD, ASH	25
		6/17/10	Neuroanatomy Review	M. Ono, PhD, ASH	0
		6/28/10	Age-Related Dementia	B. Hodel, PhD, ASH	0
		6/29/10	Seeking Safety	G. Grant, MA (under direction of Lisa Najavits, PhD, Boston University School of Medicine)	2
		6/30/10	Involuntary Medication	J. Sczbecki, LCSW, ASH	25
		6/30/10	Behavior Guidelines/ Assessment for PhDs	B. Hodel, PhD, ASH	0
		7/15/10	The Visual System	K. Wild, PhD, ASH	0
		8/3/10	ADR	S. Mohaupt, MD,	19

			ASH	
		8/5/10	Neuroanatomy	C. Mathiesen, PsyD, ASH	0
		8/12/10	Cognitive Therapy for Psychotic Symptoms	R. Morey, PhD, P. Pretkel, PhD, and A. Brotman, PhD, ASH	0
		8/12/10	Neuropsychology	K. Wild, PhD, ASH	0
		8/19/10	Brain Topography	C. Duke, PsyD, ASH	0
		8/23/10	Meditation for Therapists	C.A. Simpkins, PhD and A. Simpkins, PhD (UCSD)	0
		8/23/10	PTSD	C. Mathiesen, PsyD and H. Wood PhD, ASH	1
		8/24/10	Schizophrenia And Agitation: A Radical Reappraisal	Challakere, MD, UCLA	34
		8/26/10	RIAS/RIST	M. Ono, PhD, ASH	0

The above programs were comprehensive in range, appropriate in content and well-aligned with the needs of the facility.

Recommendation 2, April 2010:
Continue to provide comparative data regarding the average number of individuals who have had diagnoses listed as NOS and/or R/O for three or more months during the review period compared with the last period.

Findings:
ASH reported the comparative number of individuals receiving NOS, Deferred and Rule Out Diagnoses for more than 60 days. Given the facility's census, the facility has maintained progress in the finalization

of diagnoses as clinically appropriate since the last review. The following is a summary of the data:

Diagnostic category	Previous Period	Current Period
	Number of individuals in category	
Rule Out	1	6
Deferred	1	4
NOS	25	21

Other findings:
This monitor reviewed the charts of five individuals who have received diagnoses listed as NOS for three or more months. The facility's data showed that only one individual (TE) was diagnosed with Depressive Disorder NOS for more than sixty days and all other individuals who had unspecified diagnoses (for more than sixty days) were diagnosed with Cognitive Disorder NOS. The following is an outline of the reviews:

Initials	Diagnosis (NOS)
AAA	Cognitive Disorder NOS
BG	Cognitive Disorder NOS
GC	Cognitive Disorder NOS (and Mild Mental Retardation)
NG-2	Cognitive Disorder NOS
SDP	Cognitive Disorder NOS Secondary To Medication-Induced Delirium
TE	Depressive Disorder NOS

The review found substantial compliance in the charts of AAA, BG, NG-2, SDP and TE. There was evidence of partial compliance in the chart of GC due to the lack of follow-up to update the diagnosis based on results of the neuropsychological testing as clinically indicated.

		Compliance: Substantial. **Current recommendations**: 1. Continue to monitor this requirement. 2. Ensure timely and adequate follow-up to update diagnosis based on results of neuropsychological testing, as clinically appropriate.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as in D.1.a and D.1.d.i. **Findings:** Same as in D.1.a and D.1.d.i. **Compliance:** Substantial. **Current recommendations**: Same as in D.1.a and D.1.d.i.
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as in D.1.a and D.1.d.i. **Findings:** Same as in D.1.a and D.1.d.i. **Compliance:** Substantial.

		Current recommendations: Same as in D.1.a and D.1.d.i.
D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to provide specific information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review by the Medical Director/Chief of Psychiatry of justification and results of this review. **Findings:** The facility reported that no individual received "no diagnosis" on Axis I during this review period. **Other findings:** This monitor found no evidence of this diagnosis during chart reviews. **Compliance:** Substantial. **Current recommendation**: Continue to provide specific information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review by the Medical Director/Chief of Psychiatry of justification and results of this review.
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement.

		Findings: Using the DMH Weekly Physician Progress Note (PPN) Audit, ASH assessed its compliance based on an average sample of 100% of individuals with length of stay less than 60 days during the review period (March-August 2010). The facility reported a mean compliance rate of 96% with the timeliness of weekly notes that contain subjective complaints, objective findings, assessment and plan of care. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. ASH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 23% of individuals who had been hospitalized for 90 days or more. The mean compliance rate for this requirement for this review period was 100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Other findings:** This monitor reviewed the charts of 10 individuals who were admitted during the review period (AJK, GAB, KRM, MDC, RDW, REM, RF, RJS, SC and SDH). The review focused on the timeliness of the notes. Regarding the weekly notes for individuals hospitalized fewer than 60 days, the review found compliance in eight charts (AJK, GAB, KRM, RDW, REM, RF, SC and SDH) and partial compliance in two (MDC and RJS). **Compliance:** Substantial. **Current recommendation:** Continue to monitor this requirement.

D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendation 1, April 2010:** Continue to monitor this requirement. **Findings:** ASH used the DMH Monthly PPN Audit to assess compliance, based on an average sample was 23% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below. **Recommendation 2, April 2010:** In order to maintain substantial compliance, the facility needs to improve the practitioners' use of the current format for the monthly psychiatric reassessments to ensure that the reassessments consistently provide clear evaluations of the individuals' progress and that the plans of care are linked to these evaluations. **Findings:** The facility reported that all treating psychiatrists (and psychiatric nurse practitioners) were instructed (July 14, 2010) to implement the following: 1. All monthly notes are to synthesize the entire month's treatment and progress in a narrative rather than a listing of dates and occurrences or cutting and pasting data. 2. The Pharmacological Rationale/Plan Section is to summarize the individual's symptoms, use of medications, use of seclusion/restraint, and overall progress in a narrative format. 3. The Non-Pharmacological section is to include a narrative example of a group that the individual is attending and how he is benefiting from it. If the individual is choosing not to attend groups, there will be an explanation as to why interventions have been implemented. This

		section will still include Behavior Guideline information. **Recommendation 3, April 2010:** In order to maintain substantial compliance, the facility needs to correct the [process deficiencies identified in this cell in the previous report] regarding the PRN/Stat medication use. **Findings:** The facility reported a variety of corrective actions to address the previously mentioned areas of deficiency. The following summarizes these actions: 1. RN Mentors are now auditing 50% of all PRN/Stat medications and providing feedback and mentoring to nursing staff. A report is generated from the QuickHits data base daily and utilized to complete the audit the next day. 2. Practitioners now document note PRN/Stat usage on the weekly. 3. The Program Review Committee currently reviews multiple PRN use, which triggers PRC examination. 4. The STAT/NOW PPN form has been used for every Stat administration (effective July 14, 2010) including reference to any change of diagnosis or treatment if applicable as a result of this review. 5. The practitioners were instructed to ensure that Weekly and Monthly Notes clearly document either use of PRN and Stat medications or no use throughout the week/month and to include a plan to address the usage. **Other findings:** This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during the review period (DWH, JWB, LHE, NG, REA and RSD). The review focused on the documentation by psychiatrists (and nurses) of the utilization of PRN/Stat medications (as

		documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b. The review found general evidence of further improvements in the following areas: 1. Documentation, by nursing, of the circumstances leading to PRN/Stat medication use and of the individual's response using PRN/Stat Emergency Medication Note (form); 2. Consideration of Clozaril therapy for individuals who are refractory to adequate trials of other antipsychotic agents (DWH); 3. PBS referral when indicated (JWB); 4. Tracking of the use of PRN/Stat medication use (as documented in Psychiatric Progress Notes); 5. Attempts to adjust regular medication regimen in response to PRN/Stat medication use; and 6. The physician documentation following the use of Stat medications including to the rationale for the use of the medication. The review found a lack of adequate justification for the use of lorazepam as the sole PRN/Stat even for individuals who are diagnosed with substance use disorder (DWH, LHE and REA). This monitor reviewed monthly Psychiatric Progress Notes for the following 47 individuals: AB, AJH, AM, BE, CH, CRC, CU, DB, DB-2, DL, DLA, EM, FC, HMH, JA, JB, JB-2, JB-3, JF, JP, JT, KA, KC, KW, LA, LC, MB, MJ, ML, MM, MP, MT, MWM, PA, RC, RC-2, RDC, REA, RR, RS, RW, SDH, SL, SM, SS, TH, and WG. These notes were selected to represent different practitioners at the facility. The review found general evidence that the psychiatrists adequately addressed different requirements in this section. However, the psychiatric reassessments still contained too many redundancies and some inconsistencies in the information provided in different sections. This appeared to compromise the clinical significance and flow of relevant information in the reassessment. At this juncture, this monitor believes that the facility

		should simplify, with input from practitioners, the basic template of the psychiatric reassessments to improve the clinical utility of the reassessments. **Compliance:** Substantial. **Current recommendations**: 1. Continue to monitor this requirement. 2. In order to maintain substantial compliance, the current DMH template for documentation of the monthly reassessments should be streamlined to improve clinical flow of data and to optimize time spent in documentation. This task must be led by the Medical Directors of all four facilities with direct and adequate input from practitioners.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	98%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	99%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	99%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	99%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks	99%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.

	associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	98%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.
D.1.g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	**Current findings on previous recommendations:** **Recommendations 1 and 2, April 2010:** • Continue to monitor this requirement. • In order to maintain substantial compliance, ensure that the course of hospitalization section consistently provides clear review and synthesis of significant events during hospitalization.

Findings:
ASH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 27% of the individuals who experienced inter-unit transfer per month during the review period (March-August 2010). The facility reported compliance rates that ranged from 99% to 100% with the requirements in this cell. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.

Other findings:
This monitor reviewed the charts of six individuals who experienced inter-unit transfers during the review period. The following outlines the reviews:

Initials	Date of transfer
JD	7/23/10
KM	9/3/10
MDM	7/16/10
MK	8/2/10
SM	7/16/10
TS	7/29/10

The review found substantial compliance in five charts and partial compliance in one (MK). The assessment of MK did not include a plan to ensure continuity of care. Overall, there was evidence of some areas that contained unnecessary duplication of information between the WRPs and the inter-unit transfer assessments. In order to optimize time spent in documentation, the facilities are encouraged to streamline the template for this assessment to minimize the duplication of some data with the WRPs.

Compliance:
Substantial.

		Current recommendations: 1. Continue to monitor this requirement. 2. In order to maintain substantial compliance, the facility needs to ensure that all assessments include a plan to ensure continuity of care. 3. Streamline the template for this assessment to minimize duplication of data with the WRPs. This task should be led by the Medical Directors with direct input from practitioners.

2. Psychological Assessments		
		Methodology: Reviewed: DMH Psychology Assessment Monitoring summary data, March-August 2010
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Compliance:** Substantial at the time of the previous review. **Current recommendation**: Continue current practice.
D.2.b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** This monitor's documentation review found that ASH cared for a total of 17 individuals below 23 years of age who required the completion of cognitive and academic assessments within 30 days of admission. Using

<table>
<tr>
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<td>the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on a 100% sample of individuals below 23 years of age during this review period (March-August 2010) and reported a mean compliance rate of 100% for those individuals who consented to assessment. Thirteen assessments were conducted with 30 days of admission; assessments for the remaining four individuals could not be completed due to repeated refusals. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.

Compliance:
Substantial based on facility data.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>D.2.c</td>
<td>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.

Findings:
The following table shows the number of staff involved in performing evaluations, the number of staff meeting the facility’s credentialing and privileging requirements, and the number of staff observed and found to be competent:

<table>
<tr><td>1.a</td><td>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</td><td>79</td></tr>
<tr><td>1.b</td><td>Number of psychologists who meet the hospital’s credentialing and privileging requirements</td><td>79</td></tr>
<tr><td>2.a</td><td>Number of psychologists observed while undertaking</td><td>27</td></tr>
</table>
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<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td></td><td>psychological assessments</td><td></td></tr>
<tr><td>2.b</td><td>Number observed to be verifiably competent in assessment procedures</td><td>26</td></tr>
</table>

One psychologist was determined not to be proficient in observed assessment procedures; a training and development plan was developed and is being implemented.

Compliance:
Substantial based on facility data.

Current recommendation:
Continue current practice.
</td>
</tr>
<tr>
<td>D.2.d</td>
<td>Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:</td>
<td>Compliance:
Substantial based on facility data.</td>
</tr>
<tr>
<td>D.2.d.i</td>
<td>expressly state the clinical question(s) for the assessment;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2010) and reported a mean compliance rate of 100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.

Current recommendation:</td>
</tr>
</table>

		Continue to monitor this requirement.
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2010) and reported a mean compliance rate of 100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Current recommendation**: Continue to monitor this requirement.
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2010) and reported a mean compliance rate of 100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Current recommendation**: Continue to monitor this requirement.

D.2.d.iv	be based on current, accurate, and complete data;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2010) and reported a mean compliance rate of 99%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Current recommendation**: Continue to monitor this requirement.
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2010) and reported a mean compliance rate of 100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Current recommendation**: Continue to monitor this requirement.

D.2.d.vi	include the implications of the findings for interventions;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2010) and reported a mean compliance rate of 99%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Current recommendation**: Continue to monitor this requirement.
D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2010) and reported a mean compliance rate of 99%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Current recommendation**: Continue to monitor this requirement.

D.2.d. viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2010) and reported a mean compliance rate of 100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Current recommendation**: Continue to monitor this requirement.
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	ASH has completed the review of the psychological assessments of all individuals admitted prior to the Effective Date of the Enhancement Plan and where indicated, conducted re-assessments. **Compliance:** Substantial.
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a	**Compliance:** Substantial based on facility data.

	significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (March-August 2010) and reported a mean compliance rate of 99%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period. **Current recommendation**: Continue to monitor this requirement.
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 49% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (March-August 2010) and reported a mean compliance rate of 99%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period.

		Current recommendation: Continue to monitor this requirement.
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	**Current findings on previous recommendations:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 49% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (March-August 2010) and reported a mean compliance rate of 100%. Comparative data indicated that the facility maintained a compliance rate of at least 90% from the previous review period **Current recommendation**: Continue to monitor this requirement.
D.2.f.ii	if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** None. **Current recommendation**: Continue practice in place as of April 2010.
D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to	**Current findings on previous recommendation:**

<table>
<tr>
<td></td>
<td>address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</td>
<td>Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) with diagnostic uncertainties due each month during the review period (March-August 2010). The following table showing the diagnosis and the corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:

<table>
<tr><td>16.</td><td>Differential diagnosis</td><td>100%</td></tr>
<tr><td>17.</td><td>Rule-out</td><td>100%</td></tr>
<tr><td>18.</td><td>Deferred</td><td>100%</td></tr>
<tr><td>19.</td><td>No diagnosis</td><td>100%</td></tr>
<tr><td>20.</td><td>NOS diagnosis</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>D.2.g</td>
<td>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Assessment Monitoring Form, ASH reported the following data for the review period (March-August 2010):</td>
</tr>
</table>

		21.a	Number of individuals who needed assessment during the evaluation period whose primary language was not English	30
		21.b	Of those in 21.a, number of individuals who were assessed in their primary language	26
		22.a	Of those in 21.a, number of individuals who could not be assessed	0
		22.b	Of those in 22.a, number of individuals who had plans developed to meet their assessment needs	0
		23.	Of those in 22.b, number of individuals whose plans for assessment were implemented	0

Compliance:
Substantial based on facility data.

Current recommendation:
Continue to monitor this requirement.

<table>
<tr><td colspan="3">3. Nursing Assessments</td></tr>
<tr><td></td><td></td><td>Methodology:

<u>Interviewed</u>:
1. Donna Hunt, RN, HSS
2. Megan Emrich, RN, HSS, Acting Assistant Nurse Administrator
3. Rosemary Morrison, RN, Acting Nurse Administrator

<u>Reviewed</u>:
1. ASH's progress report and data
2. ASH's training rosters
3. Admission and integrated assessments and WRPs for the following 40 individuals: AG, AL, ALH, AMS, ASM, BAW, CCB, CJG, CPR, DJG, DO, DRG, DRO, DVM, EUH, HPA, JD, JKC, JWT, KBA, LEU, MAG, MJA, MM, MPP, OGV, PAJ, RDW, RJS, RJY, RL, RMR, SA, SBH, SM, TDW, TEC, TJO, TOH and VL,</td></tr>
<tr><td>D.3.a</td><td>Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:</td><td>Compliance:
Substantial.</td></tr>
<tr><td>D.3.a.i</td><td>a description of presenting conditions;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Admission Assessment Monitoring Audit, ASH assessed its compliance based on a 100% sample of admissions each month during the review period (March-August 2010):

<table>
<tr><td>1.</td><td>A description of presenting conditions</td><td>98%</td></tr>
</table>
</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of Nursing Admission Assessments for 40 individuals (AG, AL, ALH, AMS, ASM, BAW, CCB, CJG, CPR, DJG, DO, DRG, DRO, DVM, EUH, HPA, JD, JKC, JWT, KBA, LEU, MAG, MJA, MM, MPP, OGV, PAJ, RDW, RJS, RJY, RL, RMR, SA, SBH, SM, TDW, TEC, TJO, TOH and VL) found that 39 were of exceptional quality. One Nursing Admission Assessment reviewed did not have the section addressing the presenting condition completed (SA). ASH needs to continue the strategies that it has implemented to continue to produce thorough and comprehensive nursing admission assessments. These findings comport with ASH's data.

Using the DMH Nursing Integrated Assessment Monitoring Audit, ASH assessed its compliance based on a 100% sample of admissions each month during the review period (March-August 2010):

1.	*The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.*	98%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of Integrated Nursing Assessments for 40 individuals (AG, AL, ALH, AMS, ASM, BAW, CCB, CJG, CPR, DJG, DO, DRG, DRO, DVM, EUH, HPA, JD, JKC, JWT, KBA, LEU, MAG, MJA, MM, MPP, OGV, PAJ, RDW, RJS, RJY, RL, RMR, SA, SBH, SM, TDW, TEC, TJO, TOH and VL) found that ASH has maintained the quality of the Integrated Nursing Assessments since the last review. All 40 Nursing Integrated Assessments reviewed included appropriate updated clinical information

<table>
<tr><td></td><td></td><td>from the time of admission. These findings comport with ASH's data.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>D.3.a.ii</td><td>current prescribed medications;</td><td><u>Admission Assessments</u>

<table><tr><td>2.</td><td>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</td><td>100%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

<u>Integrated Assessments</u>

<table><tr><td>2.</td><td>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</td><td>99%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</td></tr>
<tr><td>D.3.a.iii</td><td>vital signs;</td><td><u>Admission Assessments</u>

<table><tr><td>3.</td><td>Vital signs</td><td>100%</td></tr></table></td></tr>
</table>

<table>
<tr><td></td><td></td><td>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

<u>Integrated Assessments</u>

<table><tr><td>3.</td><td>Vital signs</td><td>100%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</td></tr>
<tr><td>D.3.a.iv</td><td>allergies;</td><td><u>Admission Assessments</u>

<table><tr><td>4.</td><td>Allergies</td><td>99%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

<u>Integrated Assessments</u>

<table><tr><td>4.</td><td>Allergies</td><td>100%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</td></tr>
<tr><td>D.3.a.v</td><td>pain;</td><td><u>Admission Assessments</u>

<table><tr><td>5.</td><td>Pain</td><td>100%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

<u>Integrated Assessments</u></td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>5.</td><td>Pain</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
</td></tr>
<tr><td>D.3.a.vi</td><td>use of assistive devices;</td><td>
<u>Admission Assessments</u>
<table>
<tr><td>6.</td><td>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</td><td>99%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

<u>Integrated Assessments</u>
<table>
<tr><td>6.</td><td>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
</td></tr>
<tr><td>D.3.a.vii</td><td>activities of daily living;</td><td>
<u>Admission Assessments</u>
<table>
<tr><td>7.</td><td>Activities of daily living</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

<u>Integrated Assessments</u>
<table>
<tr><td>7.</td><td>Activities of daily living</td><td>100%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</td></tr>
<tr><td>D.3.a.viii</td><td>immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and</td><td><u>Admission Assessments</u>

<table><tr><td>8.</td><td>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</td><td>100%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

<u>Integrated Assessments</u>

<table><tr><td>8.</td><td>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</td><td>100%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</td></tr>
<tr><td>D.3.a.ix</td><td>conditions needing immediate nursing interventions.</td><td><u>Admission Assessments</u>

<table><tr><td>9.</td><td>Conditions needing immediate nursing interventions</td><td>100%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

<u>Integrated Assessments</u>

<table><tr><td>9.</td><td>Conditions needing immediate nursing interventions</td><td>100%</td></tr></table></td></tr>
</table>

		Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** ASH's Central Nursing Services Department's policy and procedures demonstrate that they are consistently using the Wellness and Recovery model for nursing. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Atascadero State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** ASH training rosters verified that of 22 RNs that were required to complete competency-based training regarding Nursing Assessments, all completed and passed the training. In addition, six newly hired RNs also attended and passed the training. All nurses employed at ASH have current licenses. **Compliance:** Substantial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.3.d</td><td>Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:</td><td>Compliance:
Substantial.</td></tr>
<tr><td>D.3.d.i</td><td>Initial nursing assessments are completed within 24 hours of the individual's admission;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Admission Assessment Monitoring Audit, ASH assessed its compliance based on a 100% sample of admissions each month during the review period (March-August 2010):

<table>
<tr><td>10.</td><td>Initial nursing assessments are completed within 24 hours of the individual's admission.</td><td>99%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of Nursing Admission Assessments for 40 individuals (AG, AL, ALH, AMS, ASM, BAW, CCB, CJG, CPR, DJG, DO, DRG, DRO, DVM, EUH, HPA, JD, JKC, JWT, KBA, LEU, MAG, MJA, MM, MPP, OGV, PAJ, RDW, RJS, RJY, RL, RMR, SA, SBH, SM, TDW, TEC, TJO, TOH and VL) found that all were timely completed.

Compliance:
Substantial.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>D.3.d.ii</td><td>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Integrated Assessment Monitoring Audit, ASH assessed its compliance based on a 100% sample of admissions each month during the review period (March-August 2010):

<table>
<tr><td>10.</td><td>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</td><td>93%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of Integrated Nursing Assessments for 40 individuals (AG, AL, ALH, AMS, ASM, BAW, CCB, CJG, CPR, DJG, DO, DRG, DRO, DVM, EUH, HPA, JD, JKC, JWT, KBA, LEU, MAG, MJA, MM, MPP, OGV, PAJ, RDW, RJS, RJY, RL, RMR, SA, SBH, SM, TDW, TEC, TJO, TOH and VL) found that 38 were timely completed.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
</table>

<table>
<tr>
<td>D.3.d.iii</td>
<td>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on a mean sample of 20% of WRPCs observed each month during the review period (March-August 2010):

<table>
<tr><th></th><th>Previous period</th><th>Current period</th></tr>
<tr><td>Registered Nurse attendance at WRPC</td><td>98%</td><td>98%</td></tr>
<tr><td>Psychiatric Technician attendance at WRPC</td><td>92%</td><td>88%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for RN attendance at WRPCs and decreased slightly for PT attendance.

A review of the charts of 40 individuals (AG, AL, ALH, AMS, ASM, BAW, CCB, CJG, CPR, DJG, DO, DRG, DRO, DVM, EUH, HPA, JD, JKC, JWT, KBA, LEU, MAG, MJA, MM, MPP, OGV, PAJ, RDW, RJS, RJY, RL, RMR, SA, SBH, SM, TDW, TEC, TJO, TOH and VL) found that in 37 cases, an RN attended the WRPC and in 38 cases a PT attended the WRPC.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
</table>

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Ladonna Decou, Chief of Rehabilitation 2. Rachelle Rianda, Acting Senior Rehabilitation Therapist Reviewed: 1. List of individuals who had IA:RTS assessments from March-August 2010 2. Records of the following 10 individuals who had IA:RTS assessments from March-August 2010: AEC, BDB, CLD, DM, MH, NPP, PA, RC, REM and TOJ 3. List of individuals who had Occupational Therapy assessments from March-August 2010 4. Records of the following five individuals who had Occupational Therapy assessments from March-August 2010: GHS, GJ, ISP, ME and RDT 5. List of individuals who had Physical Therapy assessments from March-August 2010 6. Records of the following five individuals who had Physical Therapy assessments from March-August 2010: DPT, EW, GC, GHS and MAT 7. List of individuals who had Speech Therapy assessments from March-August 2010 8. Records of the following four individuals who had Speech Therapy assessments from March-August 2010: JTS, PA, PS and RPM 9. List of individuals who had Vocational Rehabilitation assessments from March-August 2010 10. Records of the following eight individuals who had Vocational Rehabilitation assessments from March-August 2010: CC, DPT, JAE, JKC, MF, RH, RV and RW 11. List of individuals who had CIPRTA assessments from March-August 2010

		12. Records of the following two individuals who had CIPRTA assessments from March-August 2010: DRS and GCJ
D.4.a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Revise and update current protocols as needed according to systemic changes and evolving standards of practice. **Findings:** Current assessment protocols appear to meet generally accepted standards of care for satisfying necessary components of comprehensive rehabilitation therapy assessments. Assessment tools should be revised and updated based on changes in systemic needs and evolving standards of practice, as well as streamlined to promote optimal clinical utility. **Compliance:** Substantial. **Current recommendation**: Continue to enhance current practice.
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to improve and enhance current practice. **Findings:** Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 20% of Integrated Rehabilitation Therapy Assessments due each month for the review period March-August 2010 (total of 154 out of 781):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within five calendar days of the individual's admission and filed in the medical record];*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 10 individuals to assess compliance of IA:RTS assessments with timeliness found all records in compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period March-August 2010 (total of 17):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool,

ASH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period March-August 2010 (total of 77):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found all records in compliance.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period March-August 2010 (total of 30):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of four individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found all records

in compliance.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 50% of Vocational Rehabilitation Focused Assessments due each month for the review period March-August 2010 (total of 125 out of 250):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];*	99%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found all records in compliance.

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of CIPRTA assessments due each month for the review period March-August 2010 (total of six):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];*	100%

<table>
<tr><td></td><td></td><td>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of two individuals to assess compliance of CIPRTA assessments with timeliness found both records in compliance.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>D.4.b.i</td><td>Is accurate and comprehensive as to the individual's functional abilities;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to enhance current practice.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 20% of Integrated Rehabilitation Therapy Assessments due each month for the review period March-August 2010 (total of 154 out of 781):

<table>
<tr><td>2.</td><td>Is accurate and comprehensive as to the individual's functional abilities;</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 10 individuals to assess compliance of IA:RTS assessments with D.4.b.i criteria found all records in substantial compliance.</td></tr>
</table>

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period March-August 2010 (total of 17):

2.	*Is accurate and comprehensive as to the individual's functional abilities;*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period March-August 2010 (total of 77):

2.	*Is accurate and comprehensive as to the individual's functional abilities;*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average

sample of 100% of Speech Therapy Focused Assessments due each month for the review period March-August 2010 (total of 30):

2.	*Is accurate and comprehensive as to the individual's functional abilities;*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of four individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 50% of Vocational Rehabilitation Focused Assessments due each month for the review period March-August 2010 (total of 125 out of 250):

2.	*Is accurate and comprehensive as to the individual's functional abilities;*	99%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period March-August 2010 (total of six):

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td>2.</td><td>Is accurate and comprehensive as to the individual's functional abilities;</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of two individuals to assess compliance of CIPRTA assessments with D.4.b.i criteria found both records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.4.b.ii</td>
<td>Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to improve and enhance current practice.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 20% of Integrated Rehabilitation Therapy Assessments due each month for the review period March-August 2010 (total of 154 out of 781):
<table>
<tr><td>3.</td><td>Identifies the individual's current functional status, and</td><td>100%</td></tr>
<tr><td>4.</td><td>The skills and supports needed to facilitate transfer to the next level of care;</td><td>100%</td></tr>
</table>
</td>
</tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.

A review of the records of 10 individuals to assess compliance of IA:RTS Assessments with D.4.b.ii criteria found all records in substantial compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period March-August 2010 (total of 17):

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care;*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.

A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period March-August 2010 (total of 77):

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer*	100%

			to the next level of care;	

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.

A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period March-August 2010 (total of 30):

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care;*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.

A review of the records of four individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 50% of Vocational Rehabilitation Focused Assessments due each month for the review period March-August 2010 (total of 125 out of 250):

3.	*Identifies the individual's current functional status,*	100%

	and	
4.	*The skills and supports needed to facilitate transfer to the next level of care;*	99%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.

A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period March-August 2010 (total of six):

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care;*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.

A review of the records of two individuals to assess compliance of CIPRTA assessments with D.4.b.ii criteria found both records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

<table>
<tr>
<td>D.4.b.iii</td>
<td>Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to improve and enhance current practice.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 20% of Integrated Rehabilitation Therapy Assessments due each month for the review period March-August 2010 (total of 154 out of 781):

<table>
<tr><td>5.</td><td>Identifies the individual's life goals,</td><td>100%</td></tr>
<tr><td>6.</td><td>Strengths, and</td><td>100%</td></tr>
<tr><td>7.</td><td>Motivation for engaging in wellness activities.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all three items.

A review of the records of 10 individuals to assess compliance of IA:RTS Assessments with D.4.b.iii criteria found all records in substantial compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period March-August 2010 (total of 17):

<table>
<tr><td>5.</td><td>Identifies the individual's life goals,</td><td>100%</td></tr>
<tr><td>6.</td><td>Strengths, and</td><td>100%</td></tr>
<tr><td>7.</td><td>Motivation for engaging in wellness activities.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at
</td>
</tr>
</table>

least 90% from the previous review period for all three items.

A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period March-August 2010 (total of 77):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities.*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all three items.

A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period March-August 2010 (total of 30):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities.*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all three items.

A review of the records of four individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 50% of Vocational Rehabilitation Focused Assessments due each month for the review period March-August 2010 (total of 125 out of 250):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities.*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all three items.

A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period March-August 2010 (total of six):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities.*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all three items.

		A review of the records of two individuals to assess compliance of CIPRTA assessments with D.4.b.iii criteria found both records in substantial compliance. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to improve and enhance current practice. **Findings:** The facility reported that five out of five Rehabilitation Therapists requiring training were trained on the IA:RTS on 5/4/10 and 6/29/10. Four out of four Rehabilitation Therapists requiring follow-up training on the VRAT were trained on 3/18/10. Four out of four Rehabilitation Therapists requiring IA:RTS follow-up training were trained on 3/17/10, 3/19/10 and 3/30/10. **Compliance:** Substantial. **Current recommendation**: Continue to enhance current practice.
D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State	All conversion assessments were completed as of the April 2009 tour.

	hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.	**Compliance:** Substantial.

5. Nutrition Assessments		
D.5	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Dawn Hartman, Assistant Director of Dietetics 2. Erin Dengate, Assistant Director of Dietetics Reviewed: 1. Nutrition Care Monitoring audit data for March-August 2010 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from March-August 2010 for each assessment type 3. Records of the following two individuals with type D.5.a assessments from March-August 2010: IES and RW 4. Records of the following two individuals with type D.5.b assessments from March-August 2010: AMS and JS 5. Records of the following eight individuals with type D.5.d assessments from March-August 2010: CBC, DRC, ECG, JLS, VA, VB, VD and VRD 6. Records of the following four individuals with type D.5.e assessments from March-August 2010: AFD, BCM, JM and RRG 7. Records of the following six individuals with type D.5.f assessments from March-August 2010: CDC, FAG, JA, JDC, LML and MBW 8. Records of the following eight individuals with type D.5.g assessments from March-August 2010: AC, AD, CMV, EPD, HAC, JAW, RTD and WDR 9. Records of the following six individuals with type D.5.i assessments from March-August 2010: AEB, MWT, PPD, RDC, RMR and SB 10. Records of the following six individuals with type D.5.j.i assessments from March-August 2010: BMC, DRS, DWH, JCD, MCI and ME 11. Records of the following eight individuals with type D.5.j.ii assessments from March-August 2010: AD, BWM, JAD, JLB, MDD, RAZ, RH and RW

<table>
<tr>
<td>D.5.a</td>
<td>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</td>
<td>
Current findings on previous recommendations:

Recommendation, April 2010:
Continue to enhance current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a assessments due each month for the review period March-August 2010 (total of two):

<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>50%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>100%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>100%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>100%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>100%</td></tr>
<tr><td>9.</td><td>Progress is monitored, measured, and evaluated</td><td>N/A</td></tr>
<tr><td>10.</td><td>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</td><td>100%</td></tr>
<tr><td>11.</td><td>Recommendations are appropriate and complete</td><td>100%</td></tr>
<tr><td>12.</td><td>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</td><td>100%</td></tr>
<tr><td>13.</td><td>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</td><td>N/A</td></tr>
</table>
</td>
</tr>
</table>

		<table><tr><td>14.</td><td>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</td><td>N/A</td></tr><tr><td>15.</td><td>Assessment utilizes approved abbreviations</td><td>50%</td></tr><tr><td>16.</td><td>Assessment is concise</td><td>100%</td></tr><tr><td>17.</td><td>Assessment is legible</td><td>100%</td></tr><tr><td>18.</td><td>Each page of the assessment is signed</td><td>100%</td></tr></table> Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period, except for items 1 and 15, which were 100% in the previous period. A review of the records of two individuals to assess compliance with Nutrition type D.5.a criteria found one record in substantial compliance (RW) and one record in partial compliance (IES). The record that was completed late was completed within seven days, as it was reportedly mistaken for a 7-day referral. **Compliance:** Substantial. **Current recommendation:** Continue to monitor this requirement.
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	**Current findings on previous recommendations:** **Recommendation, April 2010:** Continue to enhance current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.b assessments due each month for the review period March-August 2010

(total of seven):

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	N/A
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data indicated that ASH maintained a compliance rate of at

<table>
<tr><td></td><td></td><td>least 90% from the previous review period for all items that were not N/A in either period.

A review of the records of two individuals to assess compliance with Nutrition type D.5.b criteria found both records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>D.5.c</td><td>For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</td><td>Not applicable. ASH does not have a skilled nursing facility unit.</td></tr>
<tr><td>D.5.d</td><td>For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to enhance current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 41% of Nutrition Type D.5.d assessments due each month for the review period March-August 2010 (total of 73 out of 179):

<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>97%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
</table>
</td></tr>
</table>

		4.	*Estimated daily needs for nutrients specified are appropriate*	100%
		5.	*Assessment utilizes findings from subjective and objective data*	99%
		6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	97%
		7	*Nutrition education is documented*	99%
		8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
		9.	*Progress is monitored, measured, and evaluated*	N/A
		10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
		11.	*Recommendations are appropriate and complete*	100%
		12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
		13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	N/A
		14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
		15.	*Assessment utilizes approved abbreviations*	100%
		16.	*Assessment is concise*	100%
		17.	*Assessment is legible*	100%
		18.	*Each page of the assessment is signed*	100%
		Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period. A review of the records of eight individuals to assess compliance with Nutrition type D.5.d criteria found six records in substantial compliance (CBC, DRC, ECG, JLS, VA and VB) and two records in partial compliance		

<table>
<tr><td></td><td></td><td>(VD and VRD).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>D.5.e</td><td>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to enhance current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e assessments due each month for the review period March-August 2010 (total of eight):

<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>100%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>100%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>100%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>100%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>100%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td>9.</td><td>Progress is monitored, measured, and evaluated</td><td>N/A</td></tr>
<tr><td>10.</td><td>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</td><td>100%</td></tr>
<tr><td>11.</td><td>Recommendations are appropriate and complete</td><td>100%</td></tr>
<tr><td>12.</td><td>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</td><td>100%</td></tr>
<tr><td>13.</td><td>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</td><td>100%</td></tr>
<tr><td>14.</td><td>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</td><td>N/A</td></tr>
<tr><td>15.</td><td>Assessment utilizes approved abbreviations</td><td>100%</td></tr>
<tr><td>16.</td><td>Assessment is concise</td><td>100%</td></tr>
<tr><td>17.</td><td>Assessment is legible</td><td>100%</td></tr>
<tr><td>18.</td><td>Each page of the assessment is signed</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.

A review of the records of four individuals to assess compliance with Nutrition type D.5.e criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.5.f</td>
<td>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to improve and enhance current practice.</td>
</tr>
</table>

Findings:
Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f assessments due each month for the review period March-August 2010 (total of 14):

1.	*Assessment is completed on time per policy*	96%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	N/A
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	N/A
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%

		17. *Assessment is legible* 100% 18. *Each page of the assessment is signed* 100% Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period, except item 1, which was 84% in the previous period. A review of the records of six individuals to assess compliance with Nutrition type D.5.f criteria found five records in substantial compliance (CDC, FAG, JA, LML and MBW) and one record in partial compliance (JDC). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to enhance current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.g assessments due each month for the review period March-August 2010 (total of 99 out of 476): 1. *Assessment is completed on time per policy* 95% 2. *All required subjective concerns are addressed* 100% 3. *All pertinent objective nutrition information is* 100%

			accurately addressed	
		4.	*Estimated daily needs for nutrients specified are appropriate*	99%
		5.	*Assessment utilizes findings from subjective and objective data*	99%
		6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
		7.	*Nutrition education is documented*	99%
		8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
		9.	*Progress is monitored, measured, and evaluated*	N/A
		10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
		11.	*Recommendations are appropriate and complete*	99%
		12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	99%
		13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	N/A
		14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
		15.	*Assessment utilizes approved abbreviations*	100%
		16.	*Assessment is concise*	100%
		17.	*Assessment is legible*	100%
		18.	*Each page of the assessment is signed*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.

A review of the records of eight individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.

		Compliance: Substantial. **Current recommendation**: Continue to monitor this requirement.
D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 25% of Nutrition assessments (all types) due each month of the review period March-August 2010 (424 out of 1706). The facility reports that a weighted mean of 100% of Nutrition admission assessments had evidence of a correctly assigned NST level. A review of the records of 52 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h. **Compliance:** Substantial. **Current recommendation**: Continue to enhance current practice.
D.5.i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to:	**Current findings on previous recommendation:**

	subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.	**Recommendation, April 2010:** Continue to improve and enhance current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 20% of Nutrition Type D.5.i assessments due each month for the review period March-August 2010 (total of 129 out of 638):

1.	*Assessment is completed on time per policy*	62%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	99%
4.	*Estimated daily needs for nutrients specified are appropriate*	97%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	98%
7.	*Nutrition education is documented*	98%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	99%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%

		<table><tr><td>14.</td><td>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</td><td>N/A</td></tr><tr><td>15.</td><td>Assessment utilizes approved abbreviations</td><td>100%</td></tr><tr><td>16.</td><td>Assessment is concise</td><td>100%</td></tr><tr><td>17.</td><td>Assessment is legible</td><td>100%</td></tr><tr><td>18.</td><td>Each page of the assessment is signed</td><td>100%</td></tr></table> Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period except for item 1, which improved slightly from 58% in the previous period. A review of the records of six individuals to assess compliance with Nutrition type D.5.i criteria found five records in substantial compliance (MWT, PPD, RDC, RMR and SB) and one record in partial compliance (AEB). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to improve and enhance current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 25% of Nutrition Type D.5.j.i assessments due each month for the review period March-August 2010 (total of 46 out of 181):

1.	*Assessment is completed on time per policy*	85%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	98%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	98%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items that were not

<table>
<tr><td></td><td></td><td>N/A in either period except for item 1, which improved slightly from 83% in the previous period.

A review of the records of six individuals to assess compliance with Nutrition type D.5.j.i criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>D.5.j.ii</td><td>Every individual will be assessed annually.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to improve and enhance current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 23% of Nutrition Type D.5.j.ii assessments due each month for the review period March-August 2010 (total of 46 out of 201):

<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>27%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>100%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>100%</td></tr>
</table>
</td></tr>
</table>

		7.	*Nutrition education is documented*	100%
		8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
		9.	*Progress is monitored, measured, and evaluated*	100%
		10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
		11.	*Recommendations are appropriate and complete*	100%
		12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
		13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
		14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
		15.	*Assessment utilizes approved abbreviations*	100%
		16.	*Assessment is concise*	100%
		17.	*Assessment is legible*	100%
		18.	*Each page of the assessment is signed*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period except item 1, which improved slightly from 22% in the previous review period.

A review of the records of eight individuals to assess compliance with Nutrition type D.5.j.ii criteria found five records in substantial compliance (BWM, JAD, JLB, MDD, RAZ) and three records in partial compliance (AD, RH and RW).

Compliance:
Substantial.

		Current recommendation: Continue to monitor this requirement.

<table>
<tr><td colspan="3">6. Social History Assessments</td></tr>
<tr><td></td><td>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</td><td>Methodology:

<u>Interviewed</u>:
1. Heidi Mikael, LCSW, Senior Supervising Social Worker
2. Janet Bouffard, LCSW, Chief of Social Work
3. Michael Ostash, LCSW, Senior Supervising Social Worker

<u>Reviewed</u>:
1. The records of the following seven individuals: DV, GB, JP, KM, RDS, SW and TA
2. ASH's Social History Progress Report (March-August 2010)
3. Integrated Assessments: Social Work Section
4. 30-Day Social History Assessments
5. Summary data on SW Progress Notes for individuals in the facility during this review period
6. Family Therapy Assessment data</td></tr>
<tr><td>D.6.a</td><td>Is, to the extent reasonably possible, accurate, current and comprehensive;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 40% of the Integrated Assessments: Social Work Sections due each month during the review period (March-August 2010):

<table>
<tr><td>1.</td><td>Is, to the extent reasonably possible, accurate</td><td>100%</td></tr>
<tr><td>2.</td><td>Current, and</td><td>100%</td></tr>
<tr><td>3.</td><td>Comprehensive: All sections are completed with at least the minimum information required in the</td><td>100%</td></tr>
</table>
</td></tr>
</table>

	instructions as applicable or indicate why the information is not available.	

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

A review of the records of seven individuals to evaluate the Integrated Assessments: Social Work Sections found that all seven assessments were current and comprehensive (DV, GB, JP, KM, RDS, SW and TA).

Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 20% of the 30-Day Psychosocial Assessments due each month during the review period (March-August 2010):

1.	*Is, to the extent reasonably possible, accurate*	99%
2.	*Current, and*	100%
3.	*Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

A review of the records of seven individuals to evaluate the 30-Day Psychosocial Assessments found that six assessments were timely and comprehensive (DV, GB, KM, RDS, SW and TA).) and one was untimely and/or was not comprehensive (JP).

Compliance:
Substantial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>D.6.b</td><td>Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 20% of the 30-Day Psychosocial Assessments due each month during the review period (March-August 2010):

<table>
<tr><td>4.</td><td>Expressly identifies factual inconsistencies among sources.</td><td>100%</td></tr>
<tr><td>5.</td><td>Resolves or attempts to resolve inconsistencies.</td><td>100%</td></tr>
<tr><td>6.</td><td>Explains the rationale for the resolution offered.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

A review of the records of seven individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies found that all seven assessments identified and resolved factual inconsistencies (DV, GB, JP, KM, RDS, SW and TA).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement</td></tr>
</table>

<table>
<tr>
<td>D.6.c</td>
<td>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</td>
<td>
Current findings on previous recommendations:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 40% of Integrated Assessments: Social Work Sections due each month during the review period (March-August 2010):

<table>
<tr><td>7.</td><td>Is included in the 7-day integrated assessment</td><td>98%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of the records of seven individuals to evaluate timeliness of the Social Work Integrated Assessment found that six assessments were timely (DV, GB, KM, RDS, SW and TA) and one was untimely (JP).

Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 20% of 30-Day Psychosocial Assessments due each month during the review period:

<table>
<tr><td>8.</td><td>Fully documented by the 30th day of the individual's admission.</td><td>95%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of the records of seven individuals to evaluate timeliness of the 30-Day Psychosocial Assessments found that six assessments were timely (DV, GB, JP, KM, SW and TA) and one was untimely (RDS).
</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement</td></tr>
<tr><td>D.6.d</td><td>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 40% of Integrated Assessments: Social Work Section due each month during the review period:

<table>
<tr><td>9.</td><td>Social factors</td><td>100%</td></tr>
<tr><td>10.</td><td>Educational status</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for item 10; the facility did not report data for item 9 in the previous review period.

A review of the records of seven individuals to evaluate documentation of the individual's social factors and educational status in the Integrated Assessments: Social Work Section found that all seven assessments included the information (DV, GB, JP, KM, RDS, SW and TA).

Using the DMH Social History Assessments Monitoring Form, ASH also assessed its compliance based on an average sample of 20% of 30-Day Psychosocial Assessments due each month during the review period:</td></tr>
</table>

9.	*Social factors*	98%
10.	*Educational status*	99%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for item 9; the facility did not present data for item 9 in the previous review period.

A review of the records of seven individuals to evaluate documentation of the individual's social factors and educational status in the 30-Day Psychosocial Assessments found that six assessments included information on the individual's educational status (DV, GB, KM, RDS, SW and TA) and one did not (JP); all seven assessments included information on the individual's social factors.

Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 20% of 30-Day Psychosocial Assessments due each month during the review period:

10.	*Social factors*	98 %

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

7. Court Assessments		
		Methodology: Interviewed: 1. David Fennell, MD, Chief of Forensic Psychiatry 2. Jennifer Brush, Forensic Services Manager Reviewed: 1. Charts of the following six individuals who were admitted under PC 1026: BRM, DN, HTV, JB, JPW and RL 2. Charts of the following six individuals who were admitted under PC 1370: DJK, EEG, GCR, JJV, RBR and WJN 3. ASH PC 1026 Report Auditing summary data (March – August 2010) 4. ASH PC 1370 Report Auditing summary data (March – August 2010) 5. Minutes of the Forensic Review Panel meetings during the review period
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	**Compliance:** Substantial.
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement.

		Findings: ASH used the DMH Court Report PC 1026 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (March-August 2010). The mean compliance rate was 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. The mean compliance rates for the requirements in D.7.a.ii through D.7.a.xi are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate. **Other findings:** A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases (BRM, DN, HTV, JB, JPW and RL). **Current recommendation**: Continue to monitor this requirement.
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement. **Findings:** ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** A review of the charts of six individuals admitted under PC 1026

		found substantial compliance in all cases (BRM, DN, HTV, JB, JPW and RL). **Current recommendation**: Continue to monitor this requirement.
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement. **Findings:** ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** A review of the charts of six individuals admitted under PC 1026 found substantial compliance in five cases (BRM, DN, HTV, JB and RL) and noncompliance in one (JPW). **Current recommendation**: Continue to monitor this requirement.
D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement. **Findings:** ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

		Other findings: A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases (BRM, DN, HTV, JB, JPW and RL). **Current recommendation**: Continue to monitor this requirement.
D.7.a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement. **Findings:** ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** A review of the charts of six individuals admitted under PC 1026 found substantial compliance in three charts (BRM, DN and JB) and partial compliance in three (HTV, JPW and RL). **Current recommendation**: Continue to monitor this requirement.
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement.

		Findings: ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases in which this requirement was applicable (BRM, JPW and RL). **Current recommendation**: Continue to monitor this requirement.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement. **Findings:** ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** A review of the charts of six individuals admitted under PC 1026 found substantial compliance in two charts (BRM and JB) and partial compliance in one (RL). This requirement was not applicable in the cases of DN, HTV and JPW. **Current recommendation:** Continue to monitor this requirement.

D.7.a. viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement. **Findings:** ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** A review of the charts of six individuals admitted under PC 1026 found substantial compliance in five charts (BRM, DN, HTV, JB and RL) and partial compliance in one (JPW). **Current recommendation:** Continue to monitor this requirement.
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement. **Findings:** ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases (BRM, DN, HTV, JB, JPW and RL).

		Current recommendation: Continue to monitor this requirement.
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	**Compliance:** Substantial.
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement. **Findings:** ASH used the DMH Court Report PC 1370 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (March-August 2010). The mean compliance rate was 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. The mean compliance rates for the requirements in D.7.b.ii through D.7.b.iv are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the

		requirement. Comparative data are listed, as appropriate. **Other findings:** A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (DJK, EEG, GCR, JJV, RBR and WJN). **Current recommendation**: Continue to monitor this requirement.
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement. **Findings:** ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** A review of the charts of six individuals admitted under PC 1370 found substantial compliance in five cases (DJK, EEG, JJV, RBR and WJN) and partial compliance in one (GCR). **Current recommendation**: Continue to monitor this requirement.
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement.

		Findings: ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (DJK, EEG, GCR, JJV, RBR and WJN). **Current recommendation**: Continue to monitor this requirement.
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, April 2009::** Continue to monitor this requirement. **Findings:** ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. **Other findings:** A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (DJK, EEG, GCR, JJV, RBR and WJN). **Current recommendation**: Continue to monitor this requirement.
D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews	**Current findings on previous recommendation:**

	and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction.	**Recommendation, April 2009::** Continue current practice. **Findings:** ASH has maintained its practice regarding this requirement. The psychiatrist forensic evaluators are either board-eligible (two psychiatrists) or board-certified in forensic psychiatry (three psychiatrists). The psychiatrists are required to keep current on their forensic CME requirements. Compliance is verified in the annual review of each forensic psychiatrist. The psychologist forensic evaluators have the requisite five years of experience to qualify as forensic evaluators per California statute. Psychologists must maintain their continuing education requirements as verified in each psychologist's annual review. The chair of the Forensic Review Panel is a forensic psychiatrist who is up-to-date on his CME requirements and who recertified his forensic boards in 2009. There are ongoing requirements to keep forensic board certification current, e.g. submission of actual forensic reports to the American Board of Psychiatry and Neurology for review. The facility's forensic review panel includes members whose primary area of specialization is not forensics. These persons have received in-service training from the chair of the Forensic Review Panel. This training includes didactic material that covers the legal history of Penal Code sections 1026 and 1370. The training further includes the legal criteria for each commitment code. Essentials of forensic report writing are presented with emphasis on sufficient clinical evidence to support the forensic opinion. The facility has maintained an effective training program since the last review. During this review period, the following forensic

<table>
<tr>
<td></td>
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<td>educational seminars were provided at the facility:

<table>
<tr><th>Date</th><th>Topic</th></tr>
<tr><td>5/10/10</td><td>Expert Testimony in Court</td></tr>
<tr><td>5/12/10</td><td>Medico-Legal Charting Practices</td></tr>
<tr><td>5/19/10</td><td>Prediction of Violence in Penal Code Section 2962 Patients</td></tr>
<tr><td>6/2/10</td><td>Penal Code Section 1026 Legal Criteria and Clinical Correlation</td></tr>
<tr><td>6/9/10</td><td>Violence Assessment in the Forensic Patient</td></tr>
<tr><td>6/16/10</td><td>Legal Criteria for Penal Code Section 1370</td></tr>
<tr><td>7/7/10</td><td>Sex Offender Assessment Here at ASH</td></tr>
<tr><td>7/14/10</td><td>Informed Consent</td></tr>
<tr><td>7/21/10</td><td>Clinical Staffing 1370: How to Apply Criteria</td></tr>
<tr><td>8/4/10</td><td>Involuntary Medication Practice: Current Legal State of the Art</td></tr>
<tr><td>8/11/10</td><td>Axis I v. Axis II Driven Violence</td></tr>
<tr><td>8/18/10</td><td>Sexually Violent Predator Law Criteria</td></tr>
<tr><td>9/15/10</td><td>Forensic Aspects of Hospital Monitoring: DOJ Consent Judgment</td></tr>
<tr><td>9/22/10</td><td>Recent Changes in In-House Involuntary Medication Procedure</td></tr>
</table>

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.7.c.i</td>
<td>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or</td>
<td>Current findings on previous recommendation:</td>
</tr>
</table>

	designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Recommendation, April 2009::** Continue current practice. **Findings:** Review of the minutes of the FRP found that ASH has maintained its compliance with this requirement. **Other findings:** Same as above. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

E. Discharge Planning and Community Integration		
		Summary of Progress: ASH has maintained substantial compliance with the requirements of this section.
E	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** Interviewed: 1. Adam Brotman, PsyD, PBS Team Leader 2. Heidi Mikael, LCSW, Senior Supervising Social Worker 3. Janet Buford, LCSW, Social Work Chief 4. Michael Ostash, LCSW, Senior Supervising Social Worker Reviewed: 1. The records of the following 23 individuals: AA, AH, AN, AS, BZ, CA, DN, DS, EA, GM, IP, JB, JC, JN, JP, JP-2, JW, JW-O, MA, MB, RA, RS and TW 2. List of individuals who have met discharge criteria in the last six months 3. List of individuals who have met discharge criteria and are still hospitalized 4. Summary data on SW progress notes for individuals in the facility during this review period (March-August 2010) Observed: 1. WRPC (Program I, unit 13, team A) for 14-day of RLP 2. WRPC (Program VI, unit 18) for quarterly review of RPV 3. WRPC (Program VI, unit 9) for quarterly review of GE
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning	Please see sub-cells for compliance findings:

<table>
<tr><td></td><td>conferences, the particular considerations for each individual bearing on discharge, including:</td><td></td></tr>
<tr><td>E.1.a</td><td>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (March-August 2010):

<table><tr><td>1.</td><td>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</td><td>99%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of the records of six individuals found that four WRPs utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (AA, CA, EA and MA). The individual's strengths, preferences, and life goals met partial compliance in the remaining two WRPs (JB and RA).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement</td></tr>
</table>

<table>
<tr>
<td>E.1.b</td>
<td>the individual's level of psychosocial functioning;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2010):

<table>
<tr><td>2.</td><td>The individual's level of psychosocial functioning</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of the records of six individuals found that all six WRPs included the individual's psychosocial functioning in the Present Status section (AA, CA, EA, JB, MA and RA).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement</td>
</tr>
<tr>
<td>E.1.c</td>
<td>any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2010):

<table>
<tr><td>3.</td><td>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of the records of six individuals found that all WRPs contained documentation that discharge barriers were discussed with the individual (AA, CA, EA, JB, MA and RA).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement</td>
</tr>
<tr>
<td>E.1.d</td>
<td>the skills and supports necessary to live in the setting in which the individual will be placed.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2010):</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td>4.</td><td>The skills and supports necessary to live in the setting in which the individual will be placed.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of the records of six individuals found that all six WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (AA, CA, EA, JB, MA and RA).

Compliance:
Substantial

Current recommendation:
Continue to monitor this requirement
</td>
</tr>
<tr>
<td>E.2</td>
<td>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (March-August 2010):

<table>
<tr><td>12.</td><td>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest</td><td>100%</td></tr>
</table>
</td>
</tr>
</table>

		extent possible, given the individual's level of functioning and legal status. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period. A review of the records of six individuals found that five WRPs contained documentation indicating that the individual was an active participant in the discharge process (AA, CA, JB, MA and RA). The remaining WRP contained no documentation that the individual participated in the discussion (EA). This monitor observed three WRPCs (GE, RLP and RPV). All three WRPTs, depending on the individual's willingness, engaged the individual in a discussion of progress and current barriers to discharge. A review of the records of six individuals found that all WRPs contained measurable objectives and interventions to address the individual's discharge criteria (AA, CA, EA, JB, MA and RA). A review of the records of six individuals found that five WRPs prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (AA, CA, EA, JB and MA). The remaining WRP did not (RA). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of	Please see subcells for compliance findings.

<table>
<tr><td></td><td>care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</td><td></td></tr>
<tr><td>E.3.a</td><td>measurable interventions regarding these discharge considerations;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2010):

<table>
<tr><td></td><td>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</td><td></td></tr>
<tr><td>6.</td><td>Measurable interventions regarding these discharge considerations</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of the WRPs of six individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in five WRPs (AA, CA, EA, JB and MA). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the</td></tr>
</table>

<table>
<tr><td></td><td></td><td>remaining one WRP (RA).

Compliance:
Substantial.

Current recommendation:
Continue monitoring this requirement</td></tr>
<tr><td>E.3.b</td><td>the staff responsible for implement the interventions; and</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (March-August 2010):

<table><tr><td>7.</td><td>The interventions specify the name(s) of specific staff responsible for implementing each one</td><td>100%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of the records of six individuals found that all six WRPs identified the staff member responsible for the interventions (AA, CA, EA, JB, MA and RA).

Compliance:
Substantial.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement</td></tr>
<tr><td>E.3.c</td><td>The time frames for completion of the interventions.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (March-August 2010):

<table>
<tr><td></td><td>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</td><td></td></tr>
<tr><td>8.</td><td>The time frames for completion of interventions</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of the records of six individuals found that all six WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (AA, CA, EA, JB, MA and RA).

Compliance:
Substantial.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement</td></tr>
<tr><td>E.4</td><td>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:</td><td>Compliance:
Substantial.</td></tr>
<tr><td>E.4.a</td><td>individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Documentation review found that 11 individuals had been referred for discharge but were still hospitalized:

<table>
<tr><th>ID</th><th>Referral Date</th><th>Current Status</th><th>SW efforts to overcome barrier</th></tr>
<tr><td>AH</td><td>12/15/09</td><td>Waiting for CONREP</td><td>Working with CONREP. He returned to CONREP and was rejected.</td></tr>
<tr><td>DS</td><td>2/6/10</td><td>Gravely ill</td><td>Individual has terminal illness.</td></tr>
<tr><td>RS</td><td>3/16/10</td><td>Returning to CONREP</td><td>CONREP asking for more to be done. Individual is a sex offender.</td></tr>
<tr><td>AS</td><td>03/19/10</td><td>Accepted for placement</td><td>Waiting for Court approval.</td></tr>
<tr><td>MB</td><td>05/13/10</td><td>CONREP declines</td><td>BPH ordered to CONREP; CONREP rescheduling hearing to oppose placement.</td></tr>
<tr><td>JN</td><td>06/08/10</td><td>CONREP accepted July</td><td>Placement delayed for 90 days due to increased symptoms.</td></tr>
</table>
</td></tr>
</table>

		2010	
AN	06/18/10	CONREP per 1026 PC	Waiting decision from CONREP re: placement.
JP	08/02/10		Waiting decision from CONREP re: placement.
JC	08/24/10	Verbally accepted to CONREP	Waiting for CONREP acceptance letter to initiate placement.
TW	09/16/10		Waiting for CONREP interview and decision.
DN	09/29/10	Accepted for placement 8/26/10	Waiting for Court approval.

At the time of the previous review, 24 individuals had been referred for discharge but were still hospitalized; 22 of those individuals were discharged during the current review period. One of the two remaining individual is to be discharged on 11/19/2010, and the other has a discharge date of 11/27/2010, but his case is to be discussed and determined due to the complexity involving health issues (terminal illness).

ASH also has discharged a large number of individuals who were not part of CONREP. For example, 287 were discharged to the community due to not meeting commitment criteria (e.g., extension hearings, new criminal charges, or child custody issues). Some were also discharged to other state hospitals. Another 29 individuals on commitment pursuant to PC 2962 PC or PC 972 are anticipated to be discharged between 12/11/10 and 5/9/11 due to expiration of their commitment terms. One-hundred and thirty-seven individuals on PC 1370 were discharged when they were identified as competent to stand trial. Two-hundred and seventeen individuals with a PC 2684 commitment were returned to CDC-R.

<table>
<tr>
<td></td>
<td></td>
<td>A review of the records of five individuals (AS, JN, JP, MB and TW) verified the facility's status report of individuals referred for discharge but still hospitalized.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>E.4.b</td>
<td>Individuals receive adequate assistance in transitioning to the new setting.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 100% of the quarterly and annual WRPs due each month during the review period (March-August 2010):

<table>
<tr><td></td><td>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:</td><td></td></tr>
<tr><td>10.</td><td>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of the records of seven individuals found that all seven WRPs contained documentation of the assistance needed by the individual in the new setting (BZ, GM, IP, JP-2, JW, JW-O and RA).

Current recommendation:</td>
</tr>
</table>

		Continue current practice.
E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of cell E.5 and sub-cells are not applicable to ASH as it does not serve children and adolescents.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress on Psychiatric Services: ASH has achieved substantial compliance with all the requirements in this section. **Summary of Progress on Psychological Services:** 1. ASH has maintained substantial compliance with the requirements of this section. 2. ASH improved its services to individuals with cognitive limitations. 3. ASH has implemented a number of strategic initiatives to reduce violence, including Peer Mentoring and Peer Mentors accompanying individuals to their Mall groups, and 1:1 behavioral nursing education and training during violence emergencies. 4. ASH has continued to improve its By Choice Incentive Program. The program has expanded with additional stores, is kept open during weekends, and the main store is very well organized and managed. Attendance to the store is high. **Summary of Progress on Nursing Services:** 1. ASH's efforts regarding the documentation of PRN and Stat medications has proven effective in that this area is in substantial compliance with this requirement of F.3. 2. Although ASH has implemented additional strategies addressing problematic issues regarding changes in status to ensure that the nursing assessments are clinically adequate and appropriate, this critical area continues to warrant intense and immediate focus. In addition, mentoring regarding shift change needs to continue. **Summary of Progress on Rehabilitation Therapy Services:** ASH has maintained substantial compliance with all of the requirements of Section F.4, and should continue to enhance and improve current practice.

	Summary of Progress on Nutrition Services: ASH has maintained substantial compliance with all of the requirements of Section F.5, and should continue to enhance and improve current practice. **Summary of Progress on Pharmacy Services:** ASH has maintained substantial compliance with the requirements of Section F.6 for eighteen months (four consecutive tours). As a result, the Court Monitor's evaluation of this section will cease per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance. **Summary of Progress on General Medical Services:** 1. ASH has maintained substantial compliance with the requirements of Section F.7. 2. The Chief of Medical Services, Douglas Shelton, MD and the Chief of the Medical Unit at ASH, Willard Towle, MD continued to provide an effective oversight system to ensure medical care that comports with generally accepted standards. **Summary of Progress on Infection Control:** ASH has maintained substantial compliance with the requirements of Section F.8. **Summary of Progress on Dental Services:** ASH's Dental Department has maintained substantial compliance in all but one area of the Enhancement Plan: refusals. The facility needs to focus its efforts on developing and implementing a formal facility-wide system for tracking and addressing refusals.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Chris Marra, MD, Staff Psychiatrist 2. Jarrod Macha, Psychiatric Technician, Standards Compliance 3. Jean Dansereau, MD, Staff Psychiatrist 4. Joshua Deane, MD, Acting Chief of Psychiatry 5. Ronald O'Brien, PharmD, Pharmacy Services Manager 6. Stephanie Chavez, AMHS, Standards Compliance 7. Stephen Mohaupt, MD, Chairman of the Medication Management EP Performance Improvement Committee 8. Veronica Quezada, MD, Staff Psychiatrist Reviewed: 1. Charts of the following 33 individuals: AAA, AB, ACA, AJG, ALB, BG, BM, DGH, DXL, EO, GP, HSH, JAW, JG, JJC, JJL, JLR, JPW, JV, KWH, LRM, MAC, MPS, NG, RDC, RM, RTM, SCK, SDH, SG, TRK, WM, and ZDS 2. ASH Admission Psychiatric Assessment Audit summary data (March – August 2010) 3. ASH Integrated Assessment: Psychiatry Section Audit summary data (March – August 2010) 4. ASH Monthly PPN Audit summary data (March – August 2010) 5. ASH PRN and Stat monitoring summary data (March – August 2010) 6. ASH TD Monitoring summary data (March – August 2010) 7. Last 14 ADRs for this reporting period 8. ASH aggregated data regarding ADRs (March – August 2010) 9. Intensive case analyses (ICAs) completed during this review period 10. Last ten MVRs for this reporting period 11. ASH aggregated data regarding medication variances (March – August 2010) 12. Intraclass and Interclass Polypharmacy graphs by psychiatry caseload

		August 2010 13. Pharmacy and Therapeutics Committee Minutes during the review period 14. Medication Review Committee Minutes during the review period 15. Drug Utilization Evaluations (DUEs) completed by ASH during this review period: Anticholinergic, Benzodiazepine, Valproic Acid and Hyperlipidemic Agents
F.1.a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	**Current findings on previous recommendations:** **Recommendation 1, April 2010:** Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary and provide specific summary outline of these updates. **Findings:** The following is a summary of the updates of DMH medication guidelines since the last review: 1. New guidelines were developed regarding the use of lithium, carbamazepine and first generation antipsychotics. 2. Changes/additions were made to existing protocols to address the following: a. Use of clozapine in terminally ill individuals in hospice care; b. Dosing and warning information regarding the use of depot olanzapine (at the recommendation of the DMH Medical Directors' Council, the DMH facilities did not register with the U.S. FDA to be eligible to dispense depot olanzapine); c. Risks of olanzapine use during pregnancy; d. Loading dose strategies for haloperidol decanoate; e. Risks of SSRI use during pregnancy; and f. Maximum doses of lithium, duloxetine and desvenlafaxine.

		In addition, the following summarizes ASH formulary changes: 1. Staff is required to crush and float all addictive medications or notify the pharmacy (and indicate in the chart the reason for not doing so). 2. Starting September 1, 2010, the use of bupropion and clonazepam must have a non-formulary request. **Recommendation 2, April 2010:** Continue to monitor this requirement. **Findings:** ASH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 47%, 45% and 23%, respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below. **Compliance:** Substantial. **Current recommendations**: 1. Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary and provide specific summary outline of these updates. 2. Continue to monitor this requirement.
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	The facility reported compliance rates of 99%–100% for all of the corresponding indicators in the admission and integrated assessments and the Monthly Progress Notes. Comparative data indicated that ASH maintained compliance rates of at least 90% since the previous review period.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>F.1.a.ii</td><td>prescribed in therapeutic amounts, as dictated by the needs of the individual served;</td><td>100% per the Monthly PPN Audit. Comparative data indicated that ASH maintained a compliance rate of at least 90% since the previous review period.</td></tr>
<tr><td>F.1.a.iii</td><td>tailored to each individual's symptoms;</td><td>Same as above.</td></tr>
<tr><td>F.1.a.iv</td><td>monitored for effectiveness against clearly identified target variables and time frames;</td><td>Same as above.</td></tr>
<tr><td>F.1.a.v</td><td>monitored appropriately for side effects;</td><td>The facility reported compliance rates of 99%-100% for the corresponding indicators in the Monthly Progress Notes. Comparative data indicated that ASH maintained compliance rates of at least 90% since the previous review period.</td></tr>
<tr><td>F.1.a.vi</td><td>modified based on clinical rationales;</td><td>Same as above.</td></tr>
<tr><td>F.1.a.vii</td><td>are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and</td><td>99% per the Monthly PPN Audit. Comparative data indicated that ASH maintained a compliance rate of at least 90% since the previous review period.</td></tr>
<tr><td>F.1.a.viii</td><td>Properly documented.</td><td>
<table>
<tr><td>Admission Psychiatric Assessment</td><td>8.a, 8.b and 8.c</td><td>100%</td></tr>
<tr><td>Integrated Assessment (Psychiatry)</td><td>7 and 10</td><td>100%</td></tr>
<tr><td>Monthly PPN</td><td>2.b, 3 and 5.a-5.d</td><td>100%</td></tr>
</table>

The facility's comparative data indicated that ASH has maintained compliance rates of at least 90% since the previous review period.
</td></tr>
<tr><td>F.1.b</td><td>Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute</td><td>Current findings on previous recommendations:

Recommendation 1, April 2010:
Continue to monitor this requirement.</td></tr>
</table>

for appropriate long-term treatment of the individual's condition.

Findings:
ASH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 23% of individuals who have been hospitalized for 90 or more days during the review period (March-August 2010). The indicator assessed the timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use. The mean compliance rate was 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% since the previous review period.

The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 68 % and 59% of PRN and Stat medications given per month, respectively. The following tables summarize the data:

Nursing Services PRN		
1.	*Safe administration of PRN medication.*	99%
2.	*Documentation of the circumstances requiring PRN medication.*	99%
3.	*Documentation of the individual's response to PRN medication.*	97%

Nursing Services Stat		
1.	*Safe administration of Stat medication.*	98%
2.	*Documentation of the circumstances requiring Stat medication.*	100%
3.	*Documentation of the individual's response to Stat medication.*	97%

Comparative data indicated that the facility has maintained compliance rates of at least 90% since the previous review period.

<table>
<tr><td></td><td></td><td>Recommendation 2, April 2010:
Same as Recommendation 3 in D.1.f.

Findings:
Same as in D.1.f.

Other findings:
Same as in D.1.f.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.1.c</td><td>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.

Findings:
ASH used the DMH Monthly PPN Audit Form to assess compliance (March-August 2010). Sample size varied based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates:

<table>
<tr><td colspan="3">PPN - Revised</td></tr>
<tr><td>5.d.</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects</td><td></td></tr>
</table>
</td></tr>
</table>

	including, if applicable, an analysis of risks and benefits of the following:	
5.d.i.	*Benzodiazepines*	97%
5.d.ii.	*Anticholinergics*	100%
5.d.iii.	*Polypharmacy*	99%

Comparative data indicated that ASH maintained compliance rates of at least 90% since the previous review period.

Additionally, ASH reported the following comparative data:

	Indicators	Previous Period	Current Period
1.	*Total number of individuals receiving benzodiazepines for 60 days or more*	98	99
2.	*Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more*	91	88
3.	*Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more*	79	79
4.	*Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)*	18	18
5.	*Total number receiving anticholinergics for 60 days or more*	95	96
6.	*Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive*	16	19

			dyskinesia or age 65 or above		
		7.	*Total number with intra-class polypharmacy*	378	398
		8.	*Total number with inter-class polypharmacy*	207	205

The above data showed that, given the number of individuals at ASH, the facility has maintained caution in the use of these classes of medications.

Other findings:
This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:

1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders;
2. Anticholinergic medications for individuals diagnosed with cognitive disorders;
3. Anticholinergic medications for elderly individuals; and
4. Various forms of polypharmacy.

This monitor also reviewed the charts of individuals receiving the above types of medication regimens. The following outlines these reviews:

Benzodiazepine use

Individual	Medication(s)	Diagnosis
AB	Lorazepam	Polysubstance Dependence
BM	Benztropine (and clonazepam	Borderline Intellectual Functioning (and Cannabis Abuse)
EO	Clonazepam	Polysubstance Dependence
GP	Lorazepam	Dementia Due To Neurosyphillis
JLR	Clonazepam	Polysubstance Dependence

JPW	Lorazepam	Borderline Intellectual Functioning
JV	Lorazepam	Polysubstance Dependence
SCK	Lorazepam	Polysubstance Dependence
WM	Clonazepam	Sedative Hypnotic Dependence
ZDS	Clonazepam	Alcohol Abuse and Cannabis Abuse

This review found substantial compliance in eight charts (AB, EO, GP, JLR, JV, SCK, WM and ZDS) and partial compliance in two (BM and JPW). The chart of JPW included inaccurate conclusions in the psychiatric reassessment regarding the impact of benzodiazepine treatment on the individual's cognitive status.

Anticholinergic use

Individual	Medication(s)	Diagnosis
BG	Diphendydramine (and lorazepam)	Cognitive Disorder NOS (and Polysubstance Dependence)
BM	Benztropine (and clonazepam	Borderline Intellectual Functioning (and Cannabis Abuse)
LRM	Benztropine	No diagnosis
MAC	Benztropine (and lorazepam)	Borderline Intellectual Functioning (and Alcohol Abuse)
RDC	Benztropine (and clonazepam)	Borderline Intellectual Functioning (and Amphetamine Abuse)
TRK	Benztropine	No diagnosis (psychiatric note), Borderline Intellectual Functioning (in the WRP)

This review found substantial compliance in four charts (BM, LRM, RDC and TRK) and partial compliance in two (BG and MAC).

This monitor found no evidence of long-term anticholinergic use for elderly individuals (age 65 or above) at the time of this review.

Polypharmacy use

Individual	Medication(s)	Diagnosis
AAA	Olanzapine, divalproex, chlorpromazine and trazodone	
ACA	Lorazepam, lithium, divalproex, haloperidol, citalopram and olanzapine	
BG	Clozaril, lithium, lorazepam, diphenhydramine, haloperidol decanoate and levetiracetam	Polysubstance Dependence and Cognitive Disorder NOS
JJL	Clozaril, risperidone and lithium, trazodone	
RM	Haloperidol, lorazepam, risperidone and olanzapine	Alcohol Abuse
RTM	Chlorpromazine, lithium, divalproex and trazodone	
SDH	Olanzapine, divalproex, lithium, quetiapine and thiothixene	Neuroleptic-induced Tardive Dyskinesia
WM	Lithium, olanzapine, quetiapine, buspirone and mirtazapine	

This review found substantial compliance in five charts (AAA, ACA, RTM, SDH and WM) and partial compliance in the charts of BG, JJL and RM.

Compliance:
Substantial.

Current recommendations:
1. Continue to monitor this requirement.
2. Provide CME update regarding the relative risks of various

<table>
<tr><td></td><td></td><td>benzodiazepine agents in individuals with substance use disorders.</td></tr>
<tr><td>F.1.d</td><td>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, April 2010:
• Continue to monitor this requirement.
• In order to maintain compliance, the facility needs to correct the [process deficiencies identified in this cell in the previous report].

Findings:
Using the DMH Monthly PPN Auditing Form, ASH assessed its compliance based on an average sample of 23% of individuals receiving these medications during the review period (March-August 2010). The facility reported a compliance rate of 97%. Comparative data indicated that the facility maintained a compliance rate of at least 90% since the previous review period.

Other findings:
This monitor reviewed the charts of ten individuals who were receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

<table>
<tr><td>Individual</td><td>Medication(s)</td><td>Diagnosis</td></tr>
<tr><td>AJG</td><td>Risperidone</td><td>Diabetes Mellitus, Hypertension and Elevated BMI</td></tr>
<tr><td>ALB</td><td>Risperidone and quetiapine</td><td>Elevated BMI, Diabetes Mellitus and Hypertension</td></tr>
<tr><td>DXL</td><td>Risperidone and fluphenazine</td><td>Hyperlipidemia, Elevated BMI, Diabetes Mellitus and Hypertension</td></tr>
<tr><td>JAW</td><td>Olanzapine</td><td>Hyperlipidemia, Obesity, Diabetes Mellitus and Hypertension</td></tr>
<tr><td>JG</td><td>Clozapine</td><td>Diabetes Mellitus and Obesity.</td></tr>
</table>
</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td>JJC</td><td>Olanzapine</td><td>Diabetes Mellitus and Obesity</td></tr>
<tr><td>JLR</td><td>Clozapine and olanzapine</td><td>Diabetes Mellitus and Elevated BMI.</td></tr>
<tr><td>MAC</td><td>Olanzapine</td><td>Hyperlipidemia, Obesity, Diabetes Mellitus and Hypertension</td></tr>
<tr><td>MPS</td><td>Olanzapine and risperidone</td><td>Diabetes Mellitus, Hypercholesterol-emia and Elevated BMI</td></tr>
<tr><td>RDC</td><td>Clozapine and haloperidol: vitals biweekly</td><td>Hyperlipidemia, Elevated BMI and Diabetes Mellitus</td></tr>
</table>

This review found substantial compliance in all charts. However, the facility needs to update its current procedure regarding the use of clozapine to improve the clinical monitoring of individuals for the potential risk of myocarditis.

Compliance:
Substantial.

Current recommendations:
1. Continue to monitor this requirement.
2. Update current procedure regarding the use of clozapine to improve clinical monitoring of individuals for the potential risk of myocarditis.
</td>
</tr>
<tr>
<td>F.1.e</td>
<td>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Movement Disorders Auditing Form, ASH assessed its compliance based on average samples ranging from 23% to 100% of individuals relevant to each indicator during the review period (March-</td>
</tr>
</table>

		August 2010). The facility reported compliance rates of 99%-100% for all of the indicators relevant to this requirement. Comparative data indicated that the facility has maintained compliance rates of at least 90% since the previous review period. **Other findings:** This monitor reviewed the charts of six individuals (DGH, HSH, JG, KWH, NG and SG) who were diagnosed with tardive dyskinesia as per the facility's database. This review found that ASH has maintained progress in the following areas: 1. Consistent completion of admission AIMS tests; 2. Consistent completion of quarterly AIMS tests and presentation of results in a manner that facilitates tracking by psychiatrists; 3. Documentation of AIMS scores in the psychiatric progress notes; 4. Inclusion of foci and corresponding objectives and interventions related to TD in the individual's WRP; 5. Use of appropriate learning outcomes in the WRP objectives related to TD (with few exceptions); 6. Avoidance of unnecessary long-term treatment with anticholinergic agents; and 7. Use of safer antipsychotic medication interventions, as clinically indicated (JG and SG). The review found that the objective related to TD was not clinically attainable in one individual (NG). In this case, the WRPT did not develop an objective that would be relevant to the individual's lack of understanding of the risks of his preference for a high-risk antipsychotic medication. **Compliance:** Substantial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.1.f</td><td>Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions (“ADR”).</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, April 2010:
• In order to maintain substantial compliance, ASH needs to continue to increase reporting of ADRs.
• Continue review and analysis of ADRs and present summary of aggregated data to address the following:
o The number of ADRs reported each month during the review period compared with number reported during the previous period;
o Classification of probability and severity of ADRs;
o Any negative outcomes for individuals who were involved in serious reactions;
o Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and
o Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).

Findings:
The following summarizes the facility’s data:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td>Total ADRs</td><td>73</td><td>85</td></tr>
<tr><td>Classification of Probability of ADRs</td><td></td><td></td></tr>
<tr><td>Doubtful</td><td>3</td><td>9</td></tr>
<tr><td>Possible</td><td>39</td><td>34</td></tr>
<tr><td>Probable</td><td>27</td><td>27</td></tr>
</table>
</td></tr>
</table>

Definite	4	1
Classification of Severity of ADRS		
Mild	15	18
Moderate	49	45
Severe	9	8

The above classification did not include 14 ADRs related to the development of Diabetes Mellitus in individuals receiving new generation antipsychotic medications.

Of the eight severe ADRs, none resulted in permanent harm to the individuals involved. The following is an outline of these ADRs:

	Date of ADR	ADR (suspected drug in parenthesis)
1	5/27/10	Lithium toxicity
2	6/15/10	Hypotension (risperidone)
3	6/30/10	Severe Extrapyramidal Syndrome (risperidone and loxapine)
4	6/30/10	Syncopy (quetiapine and lorazepam)
5	7/12/10	Syncopy (lorazepam and divalproex)
6	7/13/10	Constipation (olanzapine, aripiprazole and simvastatin)
7	7/17/10	Facial edema (lisinopril)
8	8/13/10	Hyperthermia (risperidone)

The facility conducted intensive case analyses (ICAs) on all eight severe ADRs. The ICAs utilized appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate.

Compliance:
Substantial.

<table>
<tr>
<td></td>
<td></td>
<td>Current recommendations:
1. Continue to increase reporting of ADRs.
2. Continue review and analysis of ADRs and present summary of aggregated data to address the following:
a. The number of ADRs reported each month during the review period compared with number reported during the previous period;
b. Classification of probability and severity of ADRs;
c. Any negative outcomes for individuals who were involved in serious reactions;
d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and
e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</td>
</tr>
<tr>
<td>F.1.g</td>
<td>Each State hospital shall ensure drug utilization evaluation (“DUE”) occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.

A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.

Findings:
The facility provided the following summary:

<table>
<tr><th>#</th><th>DUE (number of individuals reviewed in parentheses)</th></tr>
<tr><td>1</td><td>Use of anticholinergics (28)</td></tr>
<tr><td>2</td><td>Use of benzodiazepines (20)</td></tr>
<tr><td>3</td><td>Use of divalproex (72)</td></tr>
<tr><td>4</td><td>Use of hyperlipidemic agents (136)</td></tr>
</table>
</td>
</tr>
</table>

		The DUEs utilized appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate. **Compliance:** Substantial. **Current recommendation**: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, April 2010:** Present data to address the following: a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; c. Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc); d. Number of critical breakdown points by outcome; e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; f. Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and g. Outline of ICAs, including description of variance, recommendations and actions taken. **Findings:** The following is a summary of the data reported by ASH regarding MVRs:

Number of Medication Variances	Previous Period	Current Period
Prescribing	171	507
Transcribing	255	247
Ordering/Procurement	7	2
Dispensing	28	29
Administration	424	373
Drug Security	245	232
Documentation	1317	1260
Total variances	2381	2649

Critical Breakdown Points	Previous Period	Current Period
Total Critical Breakdown Points	2208	2451
Potential MVRs	1792	2091
Actual MVRs	416	360
# Prescribing	152	499
# Transcribing	215	214
#Ordering/Procurement	5	2
# Dispensing	18	21
# Administration	322	280
# Drug Security	240	222
# Documentation	1256	1213
Outcome A	105	0
Outcome B	1689	2091
Outcome C	391	347
Outcome D	22	13
Outcome E	1	0
Outcome F	0	0

Outcome G	0	0
Outcome H	0	0
Outcome I	0	0

Recommendation 2, April 2010:
Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.

Findings:
ASH conducted adequate review, analysis of contributing factors and corrective actions regarding patterns and trends of variances during this review period. These patterns/trends were noted in the categories of prescribing, transcribing, administration, drug security and documentation variances. No medication variances reached the threshold level for conduct of an ICA.

Compliance:
Substantial.

Current recommendations:
1. Present data to address the following:
   a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period;
   b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period;
   c. Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc);
   d. Number of critical breakdown points by outcome;
   e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved;
   f. Information regarding any intensive case analysis done for each

		reaction that was classified as category E or above; and g. Outline of ICAs, including description of variance, recommendations and actions taken. 2. Continue to provide results of analysis of patterns and trends, with corrective/educational actions related to MVRs.
F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. At the request of this monitor, the facility presented data regarding outcomes of its clinical services. The data addressed the rate per 1000 days of the following indicators: 1. Any aggression to self resulting in major injury (decrease); 2. Any peer-to-peer aggression resulting in major injury (increase); 3. Any aggression to staff resulting in major injury (increase); 4. Individuals having alleged abuse/neglect/exploitation (increase); 5. Individuals having confirmed abuse/neglect/exploitation (increase); 6. Individuals with two or more intra-class psychotropic medications for psychiatric reasons (mild increase); 7. Individuals with four or more inter-class psychotropic medications for psychiatric reasons (no change); 8. Any event involving a medication error which results in a major injury or exacerbation of a disease or disorder (no change); 9. Unique count of individuals in restraint (increase); 10. Unique count of restraint events (increase); 11. Unique count of individuals in seclusion (increase); 12. Unique count of seclusion events (increase);

		13. Individuals on benzodiazepines who are diagnosed with substance use (no significant change); 14. Individuals on benzodiazepine diagnosed with cognitive disorder (no change); 15. Elderly on anticholinergic medications (age >65) (no data for previous period); 16. Individuals diagnosed with cognitive disorder on anticholinergics (no data for previous period); 17. Individuals diagnosed with TD prescribed anticholinergics (no data for previous period). 18. Count of severe ADRs (no significant change); and 19. Count of severe medication variances (no change at zero). In addition (see C.2.o), the facility presented data regarding the following indicators: 1. Percentage of individuals receiving substance abuse services who advanced at least one stage of change (Stages 1 to 4) (no significant change); and 2. Percentage of individuals receiving substance abuse services who maintained Stage 5 (no data for previous period). These outcome measures are addressed in various forms in relevant sections of this report as well as accompanying key indicators. However, the compilation of the measures in this cell may be of benefit to the facilities and others as another tool in reviewing overall performance in those sections of the EP that can yield meaningful numerical outcomes. The data appeared to indicate positive process outcomes in several domains. However, peer-to-peer and individual-to-staff aggression resulting in major injury increased in April beyond near-term experience. A significant increase in the number and acuity level of admissions from correctional facilities during the early part of this review period appears to be the main contributing factor. As mentioned repeatedly in the

		introductions of the CM reports, the DMH is urged to continually review and analyze patterns and trends of all outcome data and implement systemic corrective actions as indicated. **Compliance:** Substantial. **Current recommendations**: 1. Same as in F.1.a through F.1.h. 2. Continue to present data regarding outcomes of mental health services.
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as in F.1.b and F.1.i. **Findings:** Same as in F.1.b and F.1.i. **Compliance:** Substantial. **Current recommendation**: Same as in F.1.b and F.1.i.
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as in F.1.b and F.1.i. **Findings:** Same as in F.1.b and F.1.i.

		Compliance: Substantial. **Current recommendation**: Same as in F.1.b and F.1.i.
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h. **Findings:** Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h. **Compliance:** Substantial. **Current recommendation**: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Substantial.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as in F.1.c, D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h. **Findings:** Same as in F.1.c, D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.

		Current recommendation: Same as in F.1.c, D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as above. **Findings:** Same as above. **Current recommendation**: Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as above. **Findings:** Same as above. **Current recommendation**: Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as above. **Findings:** Same as above.

		Current recommendation: Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as F.1.e. **Findings:** Same as F.1.e. **Current recommendations**: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Current recommendations**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as in C.2.n, C.2.o and F.1.c. **Findings:** Same as in C.2.n, C.2.o and F.1.c.

		Compliance: Substantial. **Current recommendations**: Same as in C.2.n, C.2.o and F.1.c.
F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	This requirement applies exclusively to Metropolitan State Hospital.

2. Psychological Services		
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** Interviewed: 1. Adam Brothman, PsyD, Psychologist 2. Brooke Hatcher, RT, Supplemental Activities Coordinator 3. Charles Joslin, Clinical Administrator 4. Christine Mathiesen, PhD, C-PAS Director 5. Deborah Hewitt, PhD, PBS Team Member 6. Diane Imrem, PsyD, Chief of Psychology 7. Donna Nelson, Standards Compliance Director 8. John De Morales, Executive Director 9. Karen Dubiel, Assistant to the Clinical Administrator 10. Killorin Riddell, PhD, Coordinator Psychology Specialty Services 11. Mary Marble, PT, Assistant to By Choice Coordinator 12. Matt Hennessey, PhD, Psychologist, Mall Director 13. Peter Pretkel, PhD, Psychologist 14. Rafael Romero, U.S, By Choice Coordinator 15. Richard Murray, PhD, Senior Supervising Psychologist 16. Teresa M. George, PhD, Senior Psychologist Supervisor Reviewed: 1. The records of the following 40 individuals: AA, AG, AW, BB, BM, CB, CV, DP, EM, GM, GP, IW, JB, JS, JW, KH, LA, LE, LS, MC, MD, MJ, MJC, MM, MT, OC, PG, PMN, PN, RC, RD, RE, RH, RJ, RMcK, SH, TQ, TR, TT, and WV 2. PBS staff training material 3. New Employee Orientation PBS training material 4. Psychology Specialty Services Committee Meeting Minutes 5. Completed Psychology Testing Observation Forms 6. List of PBS staff training topics 7. PBS plans implemented during this review period 8. Behavior guidelines implemented during this review period

		9. Structural and functional assessments completed during this review period. <u>Observed</u>: 1. By Choice store 2. Mall Group: Star Track, Substance Abuse Recovery Group (preparation stage) 3. Mall Group: Substance Abuse Recovery Group (action stage) 4. Mall Group: Anger Management 5. Mall Group: Cognitive Therapy for Psychotic Symptoms 6. Mall Group: Step Up to Health, Pre-Diabetic group 7. Psychology Specialty Services Meeting 8. Supplemental Activity Coordinators Meeting 9. WRPC (Program I, unit 13, team A) for 14-day of RLP 10. WRPC (Program VI, unit 18) for quarterly review of RPV 11. WRPC (Program VI, unit 9) for quarterly review of GE
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** ASH currently has three PBS teams and one DCAT. These four teams meet the required 1:300 ratio. The PBS team members meet the facility's credentialing criteria. They have and continue to receive training in PBS topics. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

<table>
<tr>
<td>F.2.a.i</td>
<td>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.

Findings:
The facility reported that 77 new employees were hired as direct care staff during the review period and all received two hours of training in PBS. The facility also reported that 1242 existing direct care staff were retrained on PBS during six-hour Annual Staff Training. In addition, data from behavioral interventions (Positive Behavior Support Plans and Behavior Guidelines) showed evidence that all staff responsible for implementing the plans were also trained.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>F.2.a.ii</td>
<td>the development and implementation of a facility-wide behavioral incentive system, referred to as “By CHOICE” that encompasses self-determination and choice by the individuals served.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Monitoring-By Choice Form, ASH assessed its compliance based on an average sample of 20% of WRPs due each month of this review period (March-August 2010):

<table>
<tr><td>2.</td><td>The By Choice point allocation is updated monthly in the individual’s Wellness and Recovery Plan.</td><td>100%</td></tr>
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Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 10 individuals found that all 10 of the WRPs reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (BB, BM, CB, JW, MC, MD, MJ, PMN, RC and RD). All 10 WRPs also contained documentation showing that the individual was given the opportunity to re-allocate his/her By Choice points.

This monitor observed three WRPCs (GE, RLP and RPV). All three of the WRPTs engaged the individuals in the By Choice point allocation process.

The facility reported that 77 staff members received training on By Choice during the review period (March-August 2010).

Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, ASH assessed its compliance based on a sample of 14% of the a.m. and p.m. Level I nursing staff:

1.	*Staff understands the goal of the By Choice system*	100%
2.	*Staff can state the current point cycle*	100%
3.	*Staff can state the procedure for assigning participation points on an individual's point card.*	100%
4.	*Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.*	100%
5.	*Staff correctly assigns an appropriate participation level and marks and individuals By Choice*	100%
6.	*Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.*	100%
7.	*Staff can correctly state the difference between a*	100%

	Baseline point card and a Reallocation point card.	
8.	*Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.*	100%
9.	*Staff can indicate that there is a system for orienting new individuals to the By Choice system.*	100%
10.	*Staff is able to state their unit or programs Incentive Store hours of operation.*	100%
11.	*Staff can correctly state what the By Choice levels indicate and how they can achieve higher levels.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

Other findings:
Using the Fidelity of Implementation by Individuals Form, ASH also assessed fidelity of By Choice implementation based on 23% sample of individuals in the facility:

1.	*The individual understands the goal of the By Choice system.*	100%
2.	*Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.*	96%
3.	*The individual can state, to the best of his/her ability how they earn points throughout the day.*	100%
4.	*The individual can state how they spend their By Choice points and what types of items they can purchase with their points.*	100%
5.	*The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.*	100%
6.	*Individual can indicate how many points he or she may earn each day.*	100%
7.	*Individual can correctly state the difference between*	97%

	a Baseline Point card and a Reallocated Point Card.	
8.	*Individual can correctly state the procedure for reallocating their By Choice points.*	98%
9.	*The individual is able to state their unit or program's incentive store hours of operation.*	99%
10.	*Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.*	99%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

Using the By Choice Monitoring Form: Satisfaction Check, ASH surveyed a mean sample of 22% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:

		Previous period	Current period
1.	*By Choice motivates me to participate in treatment*	98%	100%
2.	*The point system motivates me to improve my behavior*	99%	100%
3.	*The point system motivates me to learn new skills*	98%	99%
4.	*When staff completes my Point Card, they explain what I did to earn an FP, MP or NP*	96%	100%
5.	*My WRPT discusses By Choice with me during my WRPC*	98%	100%
6.	*During my WRPC I have input into how my points are allocated on my Point Card*	99%	100%
7.	*My WRPT uses By Choice to help me improve my behavior*	99%	100%

8.	*My WRPT uses By Choice to help me learn new skills*	98%	100%
9.	*My unit staff uses By Choice to help me improve my behavior*	98%	100%
10.	*My unit staff uses By Choice to help me learn new skills*	98%	100%
11.	*I like the selection of ITEMS at the Incentive Store*	98%	100%
12.	*I like the selection of ACTIVITIES at the Incentive Store*	100%	99%
13.	*I like the prices of the ITEMS at the Incentive Store*	97%	100%
14.	*I like the price of the ACTIVITIES at the Incentive Store*	99%	99%
15.	*Overall, I am satisfied with the By Choice Incentive system*	99%	100%

Using the Fidelity of Implementation by the By Choice Staff Form, ASH further assessed fidelity of implementation based on a 100% sample of Incentive Store staff members and By Choice representatives:

1.	*The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.*	100%
2.	*The incentive store includes a delivery system that ensures that all individuals have access to incentive items.*	100%
3.	*The incentive store is well stocked with appropriate items from the incentive list.*	100%
4.	*The incentive store has an inventory control system to track inventory and individual preferences.*	100%

		5.	*Individuals have substantive input into the items being offered in the Incentive Store.*	100%
		6.	*The incentive store has a system to track and remove outdated food items.*	100%
		7.	*There is a By Choice Manual located in the incentive store.*	100%
		8.	*The Incentive Store staff has received appropriate training regarding incentive store policies and procedures.*	100%
		9.	*The individuals bring their point cards to the store to make a purchase.*	100%
		10.	*There is a By Choice Calorie Activity Guide located in the incentive store.*	100%
		11.	*There is an Alert List in the incentive store for staff reference.*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.

Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), ASH assessed fidelity of implementation based on average samples of 14% of the Level of Care Staff, 23% of the Individuals, and 100% of the By Choice program staff. The table below is a summary of the data:

Level of Care Staff	100%
Individuals	99%
By Choice Program Staff	100%

The By Choice Incentive program continues to improve. There is now an additional store in the courtyard. The program has added a significant number of non-food items to its inventory. The central By Choice store is well managed and attendance to the store is high. Individuals enjoy

		coming to the store due to its structure and numerous activities including Wii games. There have been no incidents at the store and no codes have been called at the store even though a number of individuals display challenging behaviors in other settings but not during the times they are at the incentive store. The facility has developed a By Choice level of functioning system to evaluate the individuals' daily functioning and plans on using the data in a number of ways, including as an assessment of the individuals' treatment engagement and overall functioning. The By Choice/Psychology staff at ASH, in collaboration with the By Choice/Psychology staff from the other State facilities, has generated a number of recommendations to streamline the audit process. Most of the proposals to add/edit audit items seem reasonable and should be coordinated with the DMH consultant and the respective HOM team members for adoption. One of the issues is the monthly individual survey audits. This can be addressed in a number of ways and this monitor discussed the options with the By Choice staff, clinical administrator, and the PSSC coordinator (e.g., one way to streamline the survey is to conduct the surveys at the end of Mall group sessions on designated days). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice.

<table>
<tr><td></td><td></td><td>Findings:
The Chief of Psychology confirmed that she continues to have clinical and administrative authority for the PBS Teams and the By Choice incentive program. However, the Chief has delegated some of the responsibilities to the Coordinator of the Psychology Specialty Services Committee.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.2.c</td><td>Each State Hospital shall ensure that:</td><td>Compliance:
Substantial.</td></tr>
<tr><td>F.2.c.i</td><td>behavioral assessments include structural and functional assessments and, as necessary, functional analysis;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a sample of 100% of individuals with a new or revised behavioral assessment during the review period (March-August 2010):

<table>
<tr><td>1.</td><td>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</td><td>100%</td></tr>
<tr><td>2.</td><td>The WRPT and the PSST determined the goals of the intervention.</td><td>100%</td></tr>
<tr><td>3.</td><td>At least one specific behavior of concern was defined in clear, observable and measurable terms</td><td>100%</td></tr>
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		4.	*Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).*	100%
		5.	*Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.*	100%
		6.	*A functional assessment interview was completed for the structural assessment.*	100%
		7.	*Direct observations of the challenging behavior were undertaken, as applicable*	100%
		8.	*Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]*	100%
		9.	*A functional assessment rating scale was completed.*	100%
		10.	*Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]*	100%
		11.	*Patterns of challenging behavior were recognized based on the structural and functional assessments.*	100%
		Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items. A review of eight PBS plans (DP, EM, JS, MC, MT, RMcK, TR and TT) found that all eight had been developed and implemented based on data derived from structural and functional assessments. **Current recommendation**: Continue to monitor this requirement.		

<table>
<tr>
<td>F.2.c.ii</td>
<td>hypotheses of the maladaptive behavior are based on structural and functional assessments;</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a sample of 100% of individuals with a new or revised behavioral assessment during the review period (March-August 2010):

<table>
<tr><td>12.</td><td>Testable data-based hypotheses of the challenging behavior were developed</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of eight PBS plans (DP, EM, JS, MC, MT, RMcK, TR and TT) found that the hypotheses in all eight were based on structural and functional assessments and aligned with findings from the structural/functional assessments.

A majority of the behavioral intervention plans reviewed were well developed and meet acceptable standards. A small number still need improvement in the following areas:

1. Ensure that entries under various sections meet the accepted definitions (e.g. for MC, “becoming loud, preoccupied with other people, and difficult to redirect”, as antecedents; or for EM, “physically agitated as evidenced by pacing, posturing or increased volume or pace of speech” as antecedents is inaccurate.
2. Ensure that the functions of the behaviors are used to develop preventive strategies. (e.g. for EM, a number of setting events and antecedents were not utilized for preventative strategies).
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<table>
<tr><td></td><td></td><td>3. Provide good operational definitions of target behaviors to aid observation, reliability in data collection, and treatment integrity. For example, stating behavioral deficit as "social isolation" is a descriptor that does not lead to an easy interpretation of the context and behavioral topography (RM).
4. Use structural and functional assessment data to determine hypothesized functions, instead of stating "it is possible." Many things are possible, but what did the assessment data indicate (RM).

Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.2.c.iii</td><td>There is documentation of previous behavioral interventions and their effects;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a sample of 100% of individuals with a new or revised behavioral assessment during the review period (March-August 2010):

<table>
<tr><td>5</td><td>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of eight PBS plans (DP, EM, JS, MC, MT, RMcK, TR and TT) found that all eight had documented previous behavioral interventions and their effects.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.2.c.iv</td><td>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of new or revised PBS plans and behavior guidelines during the review period (March-August 2010):

<table><tr><td>17.</td><td>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</td><td>100%</td></tr></table>
Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of eight PBS plans (DP, EM, JS, MC, MT, RMcK, TR and TT) found that all eight behavioral interventions were based on a positive behavior supports model without any use of aversive or punishment contingencies.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.2.c.v</td><td>behavioral interventions are consistently implemented across all settings, including school settings;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>Findings:
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 16% sample of new or revised PBS plans and behavior guidelines during the review period (March-August 2010):

<table>
<tr><td>22.</td><td>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

This monitor's review of fidelity/integrity check for the PBS plans and behavior guidelines of 12 individuals (AW, CV, DP, EM, GP, JS, MC, MT, OC, RMcK, TR and TT) found that ASH had conducted fidelity checks on all 13 plans.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.2.c.vi</td>
<td>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
The table below showing the type of trigger, the number of individuals meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each of the triggers is a summary of the facility's data:</td>
</tr>
</table>

DMH Psychology Services Monitoring Form							
	Mar	Apr	May	Jun	Jul	Aug	Mean
Restraint	20	21	27	38	28	32	28
%C	100	100	100	100	100	100	100
Seclusion	26	23	32	35	36	39	32
%C	100	100	100	100	100	100	100
1:1	36	27	32	31	40	33	33
%C	100	100	100	100	100	100	100
Aggression to others	34	45	44	60	53	46	39
%C	100	100	100	100	100	100	100
Aggression to self	8	8	5	7	6	5	7
%C	100	100	100	100	100	100	100

The data above show that the PSSC reviewed all relevant cases that triggered on the various key indicators, and based on the ETRC/PSSC discussion determined cases that needed further behavioral assessment.

This monitor reviewed 10 records of individuals who triggered on one or more of the above key indicators (AA, AG, BB, KH, LA, LE, PG, RC, RD and SH). Eight had been determined to require behavioral assessments and of these seven resulted in the development and implementation of behavioral intervention plans or other treatment modalities. One did not need a plan as the target behavior was not exhibited for over 30 days (PG). One has improved in the behaviors following a unit transfer (LA).

ASH has put in place a number of initiatives to address some of the key indicators, especially those pertaining to patient violence. According to the PSSC coordinator, an analysis of violence at the facility found that individuals with cognitive limitations at the supported level were responsible for much of the violence. The facility has initiated strategies to reduce violence in this population through specialty Mall groups, Peer Mentoring, a 1370 Unit PBS plan for these individuals who

<table>
<tr><td></td><td></td><td>usually have only a brief stay at the facility, Step Up to Health Mall group, a 1:1 behavior intervention plan for nursing staff on dealing with emergency procedures for danger to self and peers, and DBT for self harm (according to the facility's data, none of the individuals undergoing DBT II have self-harmed during their time in therapy. Other initiatives include the use of debriefing as a therapeutic tool following seclusion/restraint procedures, behavior plans for medical risks, and the use of trend data from "target and replacement behavior medication graphs" during ETRC meetings and Psychology Specialty Service meetings; the graphs are also shared with program clinicians. All of these initiatives if fully implemented with integrity should help reduce violence, injury to staff and peers, and improve the quality of the individual's life.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.2.c.vii</td><td>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of new or revised PBS plans and behavior guidelines during the review period (March-August 2010):

<table>
<tr><td>11.</td><td>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>A review of eight plans (DP, EM, JS, MC, MT, RMcK, TR and TT) found that all eight contained documentation indicating that interdisciplinary discussions had been conducted (where appropriate) to better assess and address the individual's behaviors of concern.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.2.c.viii</td><td>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of new or revised PBS plans and behavior guidelines during the review period (March-August 2010):

<table>
<tr><td>19.</td><td>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</td><td>99%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 11 individuals with PBS plans or PBS assessments (BB, BM, CB, JB, MC, MD, MJ, MJC, PN, RC and RD) found that all 11 of the WRPs in the charts had properly discussed the PBS plans in the Present Status section, with objectives and interventions in the relevant sections in the WRP. In the case of MC, the plan was closed and appropriate documentation was found in the previous WRP when the plan was in effect.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.2.c.ix</td><td>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of new or revised PBS plans and behavior guidelines during the review period (March-August 2010):

<table><tr><td>24.</td><td>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</td><td>100%</td></tr></table>
Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

This monitor's review of PBS plans, outcome data, and WRPs of eight individuals (DP, EM, JS, MC, MT, RMcK, TR and TT) found that PBS teams reviewed and revised all eight PBS plans based on data trends.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.2.c.x</td><td>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Psychology Services Monitoring Form, ASH assessed its</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>compliance based on a 100% sample of PBS plans developed or revised during the review period (March-August 2010):

<table>
<tr><td>21.</td><td>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of eight PBS plans and related assessment and staff training data (DP, EM, JS, MC, MT, RMcK, TR and TT) found that the staff responsible for implementing the PBS plans had been trained to competency in all eight cases.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.2.c.xi</td>
<td>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.

Findings:
The table below showing the percentage of team members whose primary responsibility is the provision of behavioral interventions (15.a.i), the percentage of PBS team members who facilitate at least one Mall group per week (15.a.ii), and the percentage of PBS team members who, when engaged in overtime work, are assigned to PBS-related duties (15.b) is a summary of the facility's data.

<table>
<tr><td>15.a.i</td><td>All PBS team members are primarily responsible for the provision of behavioral interventions</td><td>100%</td></tr>
<tr><td>15.</td><td>All PBS team members facilitate one PSR mall group</td><td>100%</td></tr>
</table>
</td>
</tr>
</table>

		<table><tr><td>a.ii</td><td>weekly during their assigned work hours</td><td></td></tr><tr><td>15.b</td><td>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</td><td>100%</td></tr></table> PBS team members informed this monitor that there is no conflict or barrier to their primary role to provide PBS/behavioral intervention services during their normal eight-hour shift. **Current recommendation**: Continue to monitor this requirement.
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** See F.2.a.ii. **Current recommendations**: See F.2.a.ii.
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** ASH has a full DCAT team. Documentation review (training modules and topics) found that the DCAT members have been providing training to ASH staff (for example during New Employee training). The team

	developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.	members received training on PBS/BG-related information including PBS and Risk Management, Graphing and WRP Integration, Functional Behavior Assessment, Monitoring Requirement, Measuring Behaviors, Emergency Mental Health Response, Data Management, Strategic Planning, Graphing, and Staff Burnout. In addition, DCAT members also had weekly individual and group supervision. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Staff interview and review of PSSC meeting minutes found that the PSSC has met regularly and that attendance of the standing members of the Committee at these meetings has been high. The PSSC and ETRC have collaborated to review individuals with medical/behavioral issues, especially individuals who had met trigger thresholds on key indicators (aggression, self-harm, restraint, etc.). This monitor attended the PSSC meeting held during the week of the tour. The meeting was well conducted, and attention and participation during case reviews was high. The meeting was held between 3 and 4PM, and a total of 10 cases were reviewed (GM, IW, KH, LS, MM, RE, RH, RJ, TQ and WV). Case discussions were interdisciplinary in nature including psychiatry. **Compliance:** Substantial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.2.f</td><td>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.

Findings:
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of referrals received each month during the review period (March-August 2010):

<table>
<tr><th></th><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Mean</th></tr>
<tr><td>18.a.i</td><td>Number of neuro-psychological assessments due for completion in the review month</td><td>40</td><td>39</td><td>37</td><td>39</td><td>41</td><td>31</td><td>38</td></tr>
<tr><td>18.a.ii</td><td>Of those in 18.a.i, number completed</td><td>34</td><td>26</td><td>31</td><td>33</td><td>37</td><td>35</td><td>33</td></tr>
<tr><td>18.a.iii</td><td colspan="7">Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</td><td>39</td></tr>
</table>

In addition to the above assessments conducted during this review period, the Neuropsychological Services also had provided consultations on 94 cases during this review period. Neuropsychologists also facilitate Mall groups, including the Cognitive Remediation Mall groups.

Compliance:
Substantial.</td></tr>
</table>

		Current recommendation: Continue current practice.
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** Psychologists at ASH continue to have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

3. Nursing Services		
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: 1. Rosemary Morrison, RN, Acting Nurse Administrator 2. Donna Hunt, RN, HSS 3. Megan Emrich, RN, HSS, Acting Assistant Nurse Administrator Reviewed: 1. ASH's progress report and data 2. ASH's training rosters 3. ASH's Medication Variance Reports 4. Medication Administration Monitoring audit for medication observation conducted on site 5. Medical records for the following 65 individuals: AJL, ALP, AOO, AW, BJE, BLB, BR, BSB, DAW, DDM, DEH, DJM, DJW, DLB, DLG, DM, DRS, DW, DWH, ED, FSA, HAC, HC, HEZ, HLG, HMK, IJH, JA, JB, JD, JEC, JFW, JIR, JMF, JO, JR, JV, LCS, MAT, MB, MC, MDH, MJC, MJG, MJP, MM, PEG, PMN, PS, RAA, RAL, RCA, RCP, RDT, RH, RJB, RJC, RJH, RLW, RV, SJG, TWF, WAG, WEJ and WJF Observed: 1. Observation of shift report on Program I, unit 13, 2. Medication administration on Program I, unit 12 3. WRPC (Program III, unit 7) for annual review of VV 4. WRPC (Program I, unit 13) for 14-day review of RR 5. WRPC (Program I, unit 12) for 14-day review of TP
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally	**Compliance:** Substantial.

<table>
<tr><td></td><td>accepted professional standards of care, to ensure:</td><td></td></tr>
<tr><td>F.3.a.i</td><td>safe administration of PRN medications and Stat medications;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 68% mean sample of PRNs administered each month during the review period (March-August 2010):

<table><tr><td>1.</td><td>Safe administration of PRN medications</td><td>99%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on a 59% mean sample of Stat medications administered each month during the review period (March-August 2010):

<table><tr><td>2.</td><td>Safe administration of Stat medications</td><td>98%</td></tr></table>
Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of 339 PRN and Stat orders (283 PRN and 56 Stat) for 54 individuals (AJL, ALP, AOO, AW, BJE, BR, BSB, DEH, DJM, DJW, DLB, DM, DRS, DW, DWH, ED, HAC, HEZ, HLG, HMK, IJH, JA, JB, JD, JEC, JFW, JMF, JO, JR, JV, LCS, MAT, MB, MC, MDH, MJC, MJG, MJP, MM, PEG, PMN, PS, RAA, RAL, RCA, RDT, RH, RJB, RJC, RV, TWF, WAG, WEJ and WJF) found all included specific individual behaviors. In addition, all</td></tr>
</table>

<table>
<tr><td></td><td></td><td>notes reviewed included the dosages and routes of the PRN/Stat medications and the sites of the injections were documented in all notes. However, most of the sites for injections were documented by a number and there was no key for the numbers used for sites included on the PRN/Stat Emergency Medication Notes.

Current recommendations:
1. Include the key for the numbers used for injection sites on the PRN/Stat Emergency Medication Notes.
2. Continue to monitor this requirement.</td></tr>
<tr><td>F.3.a.ii</td><td>documentation of the circumstances requiring PRN and Stat administration of medications;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.

Findings:
Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 68% mean sample of PRNs administered each month during the review period (March-August 2010):

<table>
<tr><td>3.</td><td>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/ behavior requiring the medication.</td><td>97%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of 283 incidents of PRN medications for 36 individuals (ALP, AOO, AW, BJE, BR, DJM, DLB, DM, ED, HAC, HEZ, HMK, JA,JB, JD, JEC, JMF, JR, MB, MC, MDH, MJC, MJG, PEG, PS, RAA, RAL, RCA, RDT, RH, RJB, RJC, RV, TWF, WAG and WEJ) found adequate documentation</td></tr>
</table>

		in the IDNs of the circumstances requiring the PRN in 279 incidents. Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on a 59% mean sample of Stat medications administered each month during the review period (March-August 2010): 4. *There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/ behavior requiring the medication.* — 97% Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period. A review of 56 incidents of Stat medications for 18 individuals (AJL, BSB, DEH, DJW, DRS, DW, DWH, HLG, IJH, JFW, JO, JV, LCS, MAT, MJP, MM, PMN and WJF) found adequate documentation in the IDNs of the circumstances requiring the PRN in 53 incidents. **Current recommendation**: Continue to monitor this requirement.
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 68% mean sample of PRNs administered each month during the review period (March-August 2010):

5.	*There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.*	97%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of 283 incidents of PRN medications for 36 individuals (ALP, AOO, AW, BJE, BR, DJM, DLB, DM, ED, HAC, HEZ, HMK, JA,JB, JD, JEC, JMF, JR, MB, MC, MDH, MJC, MJG, PEG, PS, RAA, RAL, RCA, RDT, RH, RJB, RJC, RV, TWF, WAG and WEJ) found a timely comprehensive assessment in the IDNs of the individual's response in 281 incidents.

Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on a 59% mean sample of Stat medications administered each month during the review period (March-August 2010):

6.	*There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.*	97%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

A review of 56 incidents of Stat medications for 18 individuals (AJL, BSB, DEH, DJW, DRS, DW, DWH, HLG, IJH, JFW, JO, JV, LCS, MAT, MJP, MM, PMN and WJF) found a timely comprehensive assessment in the IDNs of the individual's response in all incidents.

Current recommendation:
Continue to monitor this requirement.

F.3.b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** Since the last review, ASH's process for MVRs continues to include the following steps: 1. MVR generated after variance discovered 2. Review by Program HSS – maintains original MVR 3. Review by Program Unit Supervisor – all MVRs 4. Review by Program Director, as applicable (all actual MVRs) 5. Review by Standards Compliance MVR Team – all MVRs for review/data agreement and identification of serious potential variances 6. Review by Pharmacy (all actual MVRs) – for ORYX benchmarking The Programs immediately contact Standards Compliance regarding any MVR suspected to be serious. The information is forwarded to the Medical Director, Central Nursing Services, Medication Management EPPI Team Leader and Standards Compliance - Licensing as applicable. The Medication Management EPPI Team reviews for Intensive Case Analysis (for serious MVRs) or In Depth Reviews (for serious potential MVRs). A review of 50 MVRs found that ASH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported. **Compliance:** Substantial. **Current recommendation:** Continue current practice.

<table>
<tr>
<td>F.3.c</td>
<td>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.

Findings:
No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See C.2.l for findings addressing WRP interventions.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>F.3.d</td>
<td>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Staff Familiarity Monitoring Audit, ASH assessed its compliance based on an average sample of 31% of the nursing staff:

<table>
<tr><td>8.</td><td>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</td><td>99%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</td>
</tr>
</table>

		In all three WRPCs observed, most team members were very familiar with the individual and the individual's WRP goals and interventions. Also, from conversation with unit staff, all were familiar with the goals and interventions of the individuals on their units. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.	**Current findings on previous recommendations:** **Recommendation 1, April 2010:** Ensure that audits regarding nursing documentation for change in status address the quality of the documentation. **Findings:** In March 2010, ASH's Central Nursing Services took over the auditing of nursing documentation related to medical transfers from change in status that was previously audited by Central Medical Services physicians. In May 2010, Case Review studies were implemented in Central Nursing Services to review nursing documentation related to transfers out to a higher level of care. These meetings are held once a month and include all HSSs (Program and CNS) and CNS RN Mentors. In July 2010, the Facility implemented Provision of Care documentation training in response to the feedback received from the April 2010 Court Monitor review regarding problematic issues related to change in status. The training was provided by the Program HSSs to the RNs in either small groups or on a one-to-one basis. Also, efforts were increased to

complete one-to-one real-time reviews and mentoring regarding documentation utilizing the already established RANs.

In September 2010, focused Physical Assessment Training regarding Respiratory Assessments was implemented. The next focused training addressing Integumentary Assessment is tentatively scheduled to begin in January 2011.

Recommendation 2, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Medical Transfer Audit, ASH assessed its compliance based on a 100% sample of individuals transferred to community hospitals each month during the review period (March-August 2010):

1.	*There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.*	97%
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	96%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for both items.

A review of the records of 11 individuals who were transferred to a community hospital/emergency room (BLB, DAW, DDM, DLG, FSA, HC, JIR, RCP, RJH, RLW and SJG) found that in spite of efforts implemented as noted above, there continued to be a number of critical problematic issues with the nursing documentation for all of the reviewed individuals. Examples of problematic issues included:

		▪ Lack of documentation regarding appropriate assessments of individuals at the time of the onset of symptoms to establish a baseline; ▪ Significant gaps in documentation after individuals were identified as experiencing a change in status; ▪ Lack of documentation that status changes had been timely reported to physician, including name of physician; ▪ Duplication of documentation in progress notes and the Change of Status form; ▪ Discrepancies in documentation between information contained in the progress notes and Change of Status forms; ▪ Some Change of Status Forms report information regarding the individual's status from previous days that was not found in the progress notes; ▪ Inconsistent use of the Change of Status forms when documenting changes in status; ▪ Inadequate and incomplete assessments and follow-up for symptoms of constipation two weeks prior for an individual who was admitted to the hospital for a partial bowel obstruction; ▪ Lack of adequate assessments for an individual with a 15-pound weight gain in two weeks with episodes of diarrhea and emesis and complaints of abdominal pain; ▪ No assessments for frequent complaints of leg pain; ▪ Inadequate assessment of an individual who had "bloody emesis"; ▪ Lack of adequate assessment and follow-up for an individual experiencing blurry vision, decrease in energy, slurred speech, pain to abdomen, and reports of feeling "drunk"; ▪ No documentation reflecting the change in status for seven days for an individual with a critically toxic blood plasma level of lithium; ▪ The lack of neurological checks and mental status documented for individuals with a significant change in mental/health status; ▪ The lack of regular assessment of bowel sounds, abdomen, and regularity of bowel movements for individuals with constipation;

		▪ No assessment documented for an individual with a decubiti for four days prior or immediately upon return from a hospitalization; ▪ No documentation that a physician was timely notified when an individual was having multiple symptoms; ▪ Lack of adequate documentation regarding an assessment of the individual's status at the time of transfer to hospital or emergency room; ▪ Difficulty in determining the actual time individuals are sent to the community hospital/ER from progress notes and change of status forms; ▪ Lack of a complete nursing assessment upon return to the facility addressing the symptoms that precipitated the hospitalization or ER visit; ▪ No consistent summary documented of treatments provided at the community hospital or ER; ▪ Illegible progress notes, signatures and titles; and ▪ A number of progress notes out of sequential order. These findings do not comport with ASH's data. Nursing reported that although the items reflected in the monitoring tool showed high compliance, the facility was aware that the quality of the nursing documentation needed improvement and had implemented training modules in attempts to address clinical issues regarding changes in status. Although the facility reported that nursing had increased efforts in real-time mentoring for issues related to change of status, the overall deficits found indicate that significant work in this area needs to continue to attain substantial compliance with this requirement. From a discussion with the Nursing staff, much of the auditing is only focused on the day the individual is transferred to the hospital, and not on reviewing the documentation indicating when a change in status occurred. For most of the cases reviewed, symptoms were noted in the documentation sometimes weeks prior to a hospitalization or ER visit but were not adequately assessed or followed.

The auditor(s) for this area should consider reading the "story" first regarding the change of status, keeping in mind that it may have begun days or weeks prior to the hospitalization or ER visit, to assess for the strengths and deficits in the nursing documentation. Reading only selective notes does not provide an accurate assessment of compliance for changes in status. In addition, clinical competency is required to be able to audit this area.

Using the DMH Nursing Services Audit, ASH assessed its compliance based on a 97% sample of Change of Shift Reports observed during in the review months (March-August 2010):

10.	*Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

Observation of shift report on unit 13 found that the report to the oncoming shift lacked clinically relevant information regarding the individuals on the unit. There was no association made with the individuals' symptoms that were mentioned and their Axis diagnoses. In addition, a number of individuals were reported as having diarrhea without mention of the need for any infection control interventions. Some of the comments during the shift report were not respectful of the individuals, especially when behaviors reported were clearly reflective of their mental health disorders. In addition, it was noted that an individual was in need of reading glasses. However, when asked about this situation, the psychiatrist in the shift report stated that due to budget cuts, the staff could not provide any glasses to the individual. There appeared to be little effort made by staff to resolve this issue. A

		review of ASH's Nursing Shift Report audit data for this unit during the review period noted no problems were found, which did not comport with the reviewer's findings. The facility needs to continue its efforts in mentoring appropriate shift reports. ASH indicated that effective September 2010, all Shift Change audits will be completed by the Central Nursing Services RN Mentors (audits were previously completed by both Central Nursing Services and Standards Compliance). Central Nursing Services HSSs provide ongoing training to the RN Mentors related to the expectations of an appropriate Shift Change. **Compliance:** Partial. **Current recommendations**: 1. Ensure that audits regarding nursing documentation for change in status address the quality of the documentation. 2. Audit change of status requirement by first reading the "story" regarding the change of status, which may begin days prior to the hospitalization or ER visit, to assess for the strengths and deficits in the nursing documentation and then score the monitoring tool. 3. Continue training modules focused on building and improving nursing competency regarding assessments and documentation addressing changes in status. 4. Ensure that audits addressing change of shift report accurately reflect the shift report observed. Continue efforts in mentoring appropriate shift reports. 5. Continue to monitor this requirement.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Substantial.

<table>
<tr>
<td>F.3.f.i</td>
<td>nursing staff are knowledgeable regarding each individual's prescribed medications;</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 65% of level of care nursing staff who are licensed and medication-certified:

<table>
<tr><td>11.</td><td>Nursing staff are knowledgeable regarding each individual's prescribed medications.</td><td>95%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

From observations of medication administration on Unit 416, the medication nurse demonstrated some good interaction with the individuals receiving medications and provided some medication education. However, the facility nurse auditing the medication administration with the reviewer was noted to be somewhat intrusive and distracting while the unit nurse administered medications. While being supportive and instructive is appropriate when auditing medication administration, the auditor needs to allow the unit nurse to demonstrate the process in order to accurately assess the procedure to provide adequate medication administration data without becoming a distraction to the process.

Current recommendations:
1. Ensure that auditors for medication administration allow the unit nurse to demonstrate the process in order to accurately assess the procedure to provide adequate medication administration data without becoming a distraction to the process.
2. Continue to monitor this requirement.
</td>
</tr>
</table>

<table>
<tr>
<td>F.3.f.ii</td>
<td>education is provided to individuals during medication administration;</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 65% of level of care nursing staff who are licensed and medication-certified:

<table>
<tr><td>12.</td><td>Education is provided to individuals during medication administration.</td><td>95%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

See F.3.f.i for reviewer's findings.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>F.3.f.iii</td>
<td>nursing staff are following the appropriate medication administration protocol; and</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 65% of level of care nursing staff who are licensed and medication-certified:

<table>
<tr><td>13.</td><td>Nursing Staff are following the appropriate medication administration protocol.</td><td>100%</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

See F.3.f.i for reviewer's findings.

Current recommendations:
See F.3.f.i.</td></tr>
<tr><td>F.3.f.iv</td><td>medication administration is documented in accordance with the appropriate medication administration protocol.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 65% of level of care nursing staff who are licensed and medication-certified:

<table>
<tr><td>14.</td><td>Medication administration is documented in accordance with the appropriate medication administration protocol.</td><td>99%</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

ASH was able to produce MVRs for the blanks found on the MTRs and Narcotic Logs during the review period. The facility continues to put significant efforts into analyzing the current medication administration system so that medication nurses have the time they need to appropriately administer medications and interact with the individuals during medication administration.</td></tr>
</table>

		Other findings: While observing medication administration, this reviewer noted that PRNs and Stat medications were not documented on the front of the Medication Administration Records. From discussions with Nursing, the facility was only documenting this information on the back of the MAR and in the progress notes. Nursing needs to document the medication, dosage, route and time administered for PRNs and Stat medications on the front of the Medication Administration Record according to generally accepted standards of practice. **Current recommendations**: 1. Provide retraining to staff addressing the need to document the medication, dosage, route and time administered for PRNs and Stat medications on the front of the Medication Administration Record. 2. Ensure that all policies/procedures addressing medication administration and documentation are in alignment with this practice. 3. Continue to monitor this requirement.
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement in the event this issue arises. **Findings:** There were no bed bound individuals during the review period. **Compliance:** Not applicable. **Current recommendation**: Continue to monitor this requirement in the event this issue arises.

F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	**Compliance:** Substantial.
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** ASH's training rosters verified that the 10 newly hired nursing staff received and passed competency-based training addressing Employee Medication Certification and five out of the 10 received and passed New Employee Psychiatric Nursing Training. Due to a low number of new employees and one instructor being out for the month of August, training classes were rescheduled for September and October. The remaining five employees will receive the training at that time. **Current recommendation**: Continue current practice.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** ASH's training rosters verified that 10 newly hired nursing staff received and passed competency-based TSI in Recovery training and eight out of 10 received and passed competency-based Therapeutic Milieu Training. The remaining two employees are scheduled to receive the training in September and October.

		Current recommendation: Continue current practice.
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** ASH's training rosters verified that seven out of 10 newly hired nursing staff had received and passed the New Employee PBS Training. The remaining three staff are scheduled to receive the training in September/October. **Current recommendation**: Continue current practice.
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** ASH's training rosters verified that 91% of existing staff are currently in compliance with this requirement. See F3.h.i. for New Employee medication certification training data. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Ladonna Decou, Chief of Rehabilitation 2. Rachelle Rianda, Acting Senior Rehabilitation Therapist Reviewed: 1. F.4 audit data for March-August 2010 2. ASH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 3. Records of the following 17 individuals participating in observed PSR Mall groups: AH, AJG, CC, CV, DWH, HP, JRB, KAT, LEB, LEU, LM, MG, MW, PBH, RSG, SLW and TLA 4. List of individuals who received direct physical therapy services from March-August 2010 5. List of individuals who received direct speech therapy services from March-August 2010 6. List of individuals who received direct occupational therapy services from March-August 2010 7. Records of the following 11 individuals who received direct physical, occupational, and speech therapy services from March-August 2010: AJH, CRC, DMM, GS, JBP, JKC, PS, RJH, SPH, VIJ and WS 8. List of individuals with a 24-Hour Rehabilitation Support Plan 9. Records of the following three individuals with 24-Hour Rehabilitation Support Plans: AJH, DRS and KB 10. List of individuals with an INPOP 11. Record of the following individual with an INPOP: DRS 12. List of individuals at high risk for falls 13. List of individuals with three or more falls in 30 days or falls resulting in major injury during the review period 14. Records for the following two individuals at high risk for falls: DBL and JJS

		15. Records for the following four individuals who had three or more falls in 30 days or a fall with a major injury during the review period: PPD, RDB, SCK and WL 16. List of individuals at high risk for skin breakdown 17. Records for the following two individuals at high risk for impaired skin integrity: GAB and HLG 18. List of individuals with an incident of a decubitus ulcer during the review period 19. Records for the following two individuals with an incident of a decubitus ulcer during the review period: ELS and RCM <u>Observed</u>: 1. Interacting Through Music PSR Mall group 2. Clay Workshop PSR Mall group 3. Social Skills PSR Mall group 4. Chorus PSR Mall group 5. Alternatives to Aggression PSR Mall group 6. Inspiring Hope PSR Mall group 7. Depression Management PSR Mall group 8. Brain Fitness-Music PSR Mall group 9. Physical Wellness through Exercise PSR Mall group
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	**Compliance:** Substantial.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to enhance current practice.

Findings:
The table below presents the number of hours scheduled versus number of hours provided in direct OT, PT and SLP treatment during the week of 8/16/10:

	Scheduled	Provided
PT	54	39
OT	25	20
SLP	22	20

The facility reported that the discrepancy in OT hours was due to two individual refusals, one individual on a medical hold, one individual missing his appointment due to a change in unit, and one individual forgetting his appointment. The discrepancy in PT hours was due to refusal by six individuals, one individual who missed his appointment, and eight individuals being rescheduled due to illness or schedule conflicts. The discrepancy in SLP hours was due to individual refusals.

Other findings:
Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 24% of individuals receiving Speech and/or Physical Therapy direct treatment during the review period March-August 2010:

1.	*The provision of direct services by rehabilitation therapy services staff*	99%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 11 individuals receiving direct occupational, physical, and/or speech therapy direct treatment to assess compliance with F.4.a.i criteria found all records in substantial compliance.

		An issue was noted with alignment of treatment interventions in that direct treatment objectives and interventions that were focused on improving functional cognitive skills were listed under Focus 6 rather than under a more appropriate focus of treatment (e.g. Focus 1). In terms of individual outcomes, objectives were either met or documentation of progress towards objectives was noted in nine out of 11 records reviewed. **Current recommendation:** Continue to improve and enhance current practice.
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to assess individuals and provide this service if clinically indicated. **Findings:** The facility reported that one individual (DRS) met criteria for an INPOP during the review period. No audit data were provided, a review of the record found it to be in substantial compliance, meeting criteria for an INPOP, with evidence of plan implementation and individual reassessment as clinically indicated. **Current recommendation**: Continue to improve and enhance current practice.
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to enhance and improve current practice.

		Findings: The facility reported that 209 out of 209 nurses identified as requiring training in the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence were trained to competency during the review period. **Compliance:** Substantial. **Current recommendation**: Continue to enhance current practice.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation 1, April 2010:** During the maintenance period, develop and implement a process to ensure that all individuals who meet criteria for the development and implementation of a 24-hour support plan to improve function or decrease risk of harm receive this service. **Findings:** The facility reported that training was provided to WRP RTs. nursing staff, and one MD in order to address this recommendation. However, it does not appear that this training has resulted in consistent referrals for individuals who may meet criteria for 24-hour plans (i.e., need staff assistance to optimize safety and/or function), or awareness as to the plan itself (i.e., plans are not consistently listed in the WRP document). Reviews of records of two individuals who had reported incidences of decubitus during the review period (ELS and RCM), one individual with an incident of aspiration pneumonia (RD), and one individual at risk for choking and aspiration (GP) found that these individuals seemed to meet criteria for 24-hour support plans, but did not receive this service. See below for additional findings regarding 24-hour support plans.

Recommendation 2, April 2010:
Continue to improve and enhance current practice.

Findings:
Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 22% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period March-August 2010:

4.	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	99%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 19 individuals participating in Rehabilitation Therapist facilitated PSR Mall groups to assess compliance with F.4.c criteria found 16 records in substantial compliance (AH, CC, CV, DWH, HP, JRB, KAT, LEB, LEU, LM, MG, MW, PBH, RSG, SLW and TLA) and one record in partial compliance (AJG).

During the record review for D.4 vocational assessments, it was noted that vocational rehabilitation active treatment objectives are not listed under Focus 9. The facility reported that this is because they are not part of a Mall group intervention. However, if these objectives are active treatment objectives, they should be listed in the recovery plan.

In terms of individual outcomes, objectives were either met or documentation of progress towards objectives was noted in 13 out of 18 records reviewed.

Observation of eight PSR Mall groups found that the appropriate lesson plan was in use in all groups and that the groups provided activities that were in line with the individuals' assessed needs.

Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of individuals with 24-hour support plans during the review period March-August 2010 (total of seven):

4.	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of records of three individuals with 24-hour support plans to assess compliance with F.4.c criteria found two records in substantial compliance (DRS and KB) and one record in partial compliance (AJH). The record for AJH indicated that the 24-hour plan was not updated following an MBS that resulted in a change in nutritional supports and diet. While supports for AJH and KB were listed in the WRP, the 24-hour support plan was not listed.

The table below presents the number of hours scheduled versus number of hours provided in PSR Mall Services facilitated by Rehabilitation Therapists and Vocational Rehabilitation during the week of 8/16/10:

	Scheduled	Provided
RT	285	273
Voc Rehab	83	60

The facility reported that the reason for the discrepancy between hours scheduled and hours provided was lack of coverage and staffing due to

		illness and vacation. **Other findings:** A review of individuals who had three or more falls in 30 days or fall resulting in major injury and individuals at high risk for falls found that when clinically indicated, one record had adequate documentation of both therapy services assessment and treatment plan (e.g., 24-hour support plan, direct treatment objective and intervention) to remediate fall risk and/or future occurrence (RDB), and two did not (JJS and SCK). A review of individuals who had an incident of decubitus or were at high risk for impaired skin integrity found that when clinically indicated, one record had documentation of partial therapy services assessment and plan to remediate decubitus risk and/or future occurrence (ELS) and one record did not (RCM). **Compliance:** Substantial. **Current recommendations**: 1. During the maintenance period, ensure that all individuals who meet criteria for the development and implementation of a 24-hour support plan to improve function or decrease risk of harm receive this service. 2. Continue to improve and enhance current practice.
F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to enhance current practice. **Findings:** Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of individuals added to the adaptive

equipment database each month during the review period March-August 2010:

e.	*The individual was assessed for the appropriateness of adaptive equipment by an RT professional*	100%
f.	*The individual was provided with the equipment as per the doctor's order*	100%
g.	*The individual's level of functioning related to independence versus supports needed was assessed.*	100%
h.	*Training for the individual on the use of adaptive equipment was provided.*	100%
i.	*Reassessment of adaptive equipment, if clinically indicated*	100%

Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period for all items.

Compliance:
Substantial.

Current recommendation:
Continue to enhance current practice.

5. Nutrition Services		
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Dawn Hartman, Assistant Director of Dietetics 2. Erin Dengate, Assistant Director of Dietetics Reviewed: 1. Lists of individuals with Nutrition Care Assessments due from March-August 2010 for each assessment type 2. Records of the following 19 individuals with types a-j.ii assessments from March-August 2010: AD, AEB, BMC, CDC, DRS, FAG, IES, JAD, JDC, JLB, JS, MAC, MDD, ME, MWT, PPD, RDC, RMR and RW 3. Meal Accuracy Report audit data from March-August 2010 4. Nutrition Care Monitoring Tool audit data from March-August 2010 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 5. List of individuals with choking and aspiration pneumonia incidents during the review period 6. List of individuals at risk for choking 7. Records for the following three individuals at risk for choking /aspiration: ACW, GP and MDH 8. List of individuals at risk for aspiration 9. Record for the following individual with an incident of aspiration pneumonia during the review period: RD 10. List of individuals with a new diabetes diagnosis during the review period 11. Records for the following two individuals with a new diabetes diagnosis of diabetes during the review period: DH and JL 12. List of individuals at risk for metabolic syndrome 13. Records for the following three individuals at high risk for metabolic syndrome: JAD, RE and SRC

<table>
<tr><td></td><td></td><td>14. Records for the following three individuals participating in the Step Up to Wellness PSR mall group: AED, RC and WLB

<u>Observed</u>:
Step Up to Wellness PSR Mall group</td></tr>
<tr><td>F.5.a</td><td>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to enhance current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 25% of Nutrition Assessments (all types) due each month from March-August 2010 (total of 424 out of 1706):

<table>
<tr><td>7.</td><td>Nutrition education is documented.</td><td>99%</td></tr>
<tr><td>8</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.

A review of the records of 17 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial compliance.

ASH assessed its compliance with tray accuracy based on an average sample of 43% of average daily census from March-August 2010 (total of 2657 out of 6304) and found that 97% of trays audited were in 100%</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>compliance.

Other findings:
A review of records for individuals at high risk for metabolic syndrome and with a new diagnosis of diabetes found that all five individuals had evidence of a nutrition assessment and acuity level commensurate with level of risk (e.g., both individuals with a new diabetes diagnosis were seen monthly with an acuity level of IV) that addressed either risk factors or appropriate contributing factors. All five had evidence of an objective and intervention in place to reduce risk, either implemented by the dietitian or by nursing and in line with findings of nutrition assessment and recommendations.

Compliance:
Substantial.

Current recommendation:
Continue to enhance current practice.</td>
</tr>
<tr>
<td>F.5.b</td>
<td>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to enhance current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance with WRP integration based on an average sample of 25% of Nutrition Assessments (all types) due each month from March-August 2010 (424 out of 1706):

<table>
<tr><td>19.</td><td>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</td><td>99%</td></tr>
<tr><td>20.</td><td>The WRP has at least one objective and intervention</td><td>100%</td></tr>
</table>
</td>
</tr>
</table>

				linked to the Focus that pertains to the nutrition recommendation as clinically indicated	| Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period for both items. A review of the records of nine individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found all records in substantial compliance. **Other findings:** A review of records for three individuals participating in the Step Up to Wellness PSR Mall group to assess for compliance with provision of timely and adequate Nutrition services found one record in substantial compliance (RC) and two individuals in partial compliance (AED and WLB). Both of these records had evidence of a completed progress note, but no evidence of documentation of progress in the Present Status section of the WRP. Observation of the Step Up to Wellness PSR Mall group found that the appropriate lesson plan was in use and that the group provided activities that were in line with the individuals' assessed needs. **Compliance:** Substantial. **Current recommendation**: Continue to enhance current practice.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or	**Current findings on previous recommendation:**

	dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Recommendation, April 2010:** Continue to enhance current practice. **Findings:** Current dysphagia procedures and screening tools should continue to be updated to reflect standards of practice and to ensure consistency with procedures at other state hospitals. **Other findings:** A review of three individuals who were at risk for choking and aspiration found that when clinically indicated, all three had documentation of an open focus, objective and intervention and/or supports to remediate risk and/or future occurrence. One individual (GP) was placed on a restrictive diet with 1:1 supervision, but no clinical rationale for this support was found in the WRP. No evidence of a speech therapy referral or assessment was found for MDH or GP, although this service appeared to be clinically indicated. Review of a record of an individual with a reported incident of aspiration pneumonia (RD) found that he was seen monthly by the speech therapist for reassessment due to dysphagia. While he had an objective in place aimed at identifying choking prevention strategies, it appears that he may have benefited from an individualized plan to ensure that he exhibited safe eating practices. **Compliance:** Substantial. **Current recommendation**: Continue to enhance current practice.
F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice.

	commensurate with their responsibilities.	**Findings:** One new Dietitian was hired during the review period and was trained to competency on basic issues related to aspiration and dysphagia. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** The facility reported that no individuals currently receive enteral nutrition. The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

<table>
<tr><td colspan="3">6. Pharmacy Services</td></tr>
<tr><td></td><td>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</td><td>Methodology:

Interviewed:
Ronald O'Brien, PharmD, Pharmacy Services Manager

Reviewed:
1. Pharmacists' recommendations on new and any change to existing psychotropic medication orders (March – August 2010)
2. Data regarding pharmacists' recommendations pertaining to new psychotropic medication orders (March – August 2010)
3. Data regarding recommendations made by the pharmacists and physicians' response to these recommendations (March – August 2010)</td></tr>
<tr><td>F.6.a</td><td>Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
The following is a summary of the facility's data regarding the recommendations made during the current review period:

<table>
<tr><th></th><th></th><th>Previous period</th><th>Current period</th></tr>
<tr><td>1.</td><td>Drug-drug interactions</td><td>33</td><td>27</td></tr>
<tr><td>2.</td><td>Side effects</td><td>14</td><td>38</td></tr>
<tr><td>3.</td><td>Need for laboratory testing</td><td>25</td><td>25</td></tr>
<tr><td>4.</td><td>Dose adjustment</td><td>43</td><td>77</td></tr>
<tr><td>5.</td><td>Indications</td><td>12</td><td>8</td></tr>
<tr><td>6.</td><td>Contraindications</td><td>3</td><td>2</td></tr>
<tr><td>7.</td><td>Need for continued treatment</td><td>21</td><td>80</td></tr>
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<table>
<tr><td>8.</td><td>Others, including food-drug interactions, allergy issues, etc.</td><td>79</td><td>128</td></tr>
<tr><td colspan="2">Total number of recommendations*</td><td>230</td><td>385</td></tr>
</table>

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>F.6.b</td>
<td>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
ASH has maintained its performance in ensuring physicians' consideration of pharmacy recommendations as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td>Recommendations followed</td><td>230</td><td>385</td></tr>
<tr><td>Recommendations not followed, but rationale documented</td><td>0</td><td>0</td></tr>
<tr><td>Recommendations not followed and rationale/response not documented</td><td>0</td><td>0</td></tr>
</table>
Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
</table>

7. General Medical Services		
		Methodology: Interviewed: 1. Ana Onglao, MD, Physician and Surgeon 2. Art Onglao, MD, Physician and Surgeon 3. Ali Akhavan, M.D, Physician and Surgeon 4. Douglas Shelton, MD, Chief Physician and Surgeon 5. Joshua Deane, MD, Acting Chief of Psychiatry 6. Hussein Akhavan, M.D, Physician and Surgeon 7. Phil Wichmann, MD, Physician and Surgeon 8. Francis Castrejon, MD, Physician and Surgeon 9. Susan Smith, MD, Physician and Surgeon 10. Rosie Morrison, RN, Acting Nurse Administrator 11. Hani Boutros, MD, Physician and Surgeon 12. Willard Towle, MD, Physician and Surgeon Reviewed: 1. The charts of the following 12 individuals: BB, DAW, DDM, DLG, FSA, HC, JR, RCP, RJH, RL, RW and SJG 2. Quarterly Progress Notes on the following 13 individuals: BR, BRT, BU, DXL, EDR, GP, JV, LEB, NCT, NT, RJ, TH and TJP 3. List of all individuals admitted to external hospitals and transferred to the hospital's internal medical unit 1 during the review period 4. Reference for Assessment and Notification (RAN) for Infection 5. ASH Medical-Surgical Progress Note Audit summary data (March – August 2010) 6. ASH Integration of Medical Conditions into the WRP Audit summary data (March – August 2010) 7. ASH Medical Emergency Response (Actual) Audit summary data (March to July 2010) 8. ASH Medical Emergency Response Drill Audit summary data (March – August 2010)

		9. Summary information on Medical Emergency Response Drills conducted during the review period 10. ASH Medical Transfer Audit summary data (March – August 2010) 11. Hospital Paperwork Received within Seven Days of Patient Admitted to ASH summary data (March – August 2010) 12. ASH Diabetes Mellitus Audit summary data (March – August 2010) 13. ASH Hypertension Audit summary data (March – August 2010) 14. ASH Dyslipidemia Audit summary data (March – August 2010) 15. ASH Asthma/COPD Audit summary data (March – August 2010) 16. ASH Process and Clinical Outcome summary data (previous and current reporting period) for the following indicators: • Diabetes Mellitus • Dyslipidemia • Obesity • Hypertension • Bowel Dysfunction • Falls • Aspiration Pneumonia • Seizure Disorder • Unexpected Mortalities
F.7.a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1-3, April 2010:** • Continue current practice. • Implement corrective actions to address this monitor's findings of process deficiencies. • Provide a summary outline of any changes in policies and procedures regarding medical care to individuals during the review period. **Findings:** ASH has addressed the process deficiencies outlined in the previous report. The following is a summary of the facility's corrective actions:

1. Central Nursing Services has increased training of nursing staff in the requirements regarding assessment of changes in the status of individuals and documentation of this assessment in the Nursing Change of Condition forms.
2. The Physicians and Surgeons and Family Nurse Practitioners were notified that documentation of the assessments of individuals upon transfers from Unit 1 to the Psychiatric Treatment Units should include the reasons for the acute transfer and what further care and precautions are needed. This information was also reiterated and discussed in the Department of Medicine Committee meeting.
3. The Quarterly Medical Progress Note Database was implemented in its final form with stepwise utilization. The facility anticipated 100% utilization by November 2010, which should allow auditing and retrieval of medical information with availability to the WRPTs online.

Other findings:
This monitor reviewed the charts of 12 individuals who were transferred to the facility's medical unit or to an outside medical facility during this reporting period. The monitor also interviewed the practitioners who were involved in the care of these individuals. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):

Individual	Date/time of MD evaluation	Reason for transfer
1.	3/31/10	R/O Spontaneous Bacterial Peritonitis
2.	4/24/10	R/O Stroke
3.	5/27/10	Lithium Toxicity
4.	6/1/10	R/O Pancreatitis
5.	6/17/10	R/O Impaction
6.	6/22/10	R/O Bowel Obstruction vs. Ileus

7.	7/1/10	Abdominal Pain
8.	7/2/10	R/O Myocardial Infarction
9.	7/5/10	R/O Pneumonia
10.	7/21/10	Abdominal Pain
11.	8/15/10	Seizures
12.	8/20/10	Gastrointestinal Bleed

The review found general evidence of timely and appropriate medical care and documentation of this care.

The only significant deficiency involved an individual (HC) who developed lithium toxicity (at a critical level of 3.2) without evidence of adequate documentation of an assessment of the individual's clinical status at ASH. It appeared that this individual was started on a higher dose of lithium than was prescribed for him upon his admission to ASH as a transfer from another facility and that this increase was not guided by necessary laboratory monitoring. However, the facility conducted an adequate investigation, including corrective actions, to address this event.

This review found a number of persistent process deficiencies regarding nursing assessments of changes in the status of the individuals. Despite these deficiencies, it was evident that the Physicians and Surgeons at ASH provided timely and appropriate medical care, which appeared to be the main factor in preventing harm to any of the individuals. However, these deficiencies indicate need for further systemic corrective actions in nursing oversight to ensure adequate medical care. The following outlines the findings:

1. There was no evidence of nursing interventions to address bowel dysfunction in an individual diagnosed with Dementia NOS, Hydrocephalus and Constipation (RP).
2. The nursing assessments of two individuals who complained of abdominal pain and were later transferred to an outside facility were

		inadequate (BB and JR). 3. There was evidence of untimely and inappropriate nursing (and psychiatric) assessments of an individual who had persistent complaints regarding leg pains and inability to move legs associated with unstable vital signs (FA). 4. There was evidence that nursing staff did not execute, in a timely manner, a physician order for Stat blood work on May 23, 2010. **Compliance:** Substantial. **Current recommendations:** 1. Continue current practice in medical care. 2. Implement further corrective actions to address this monitor's findings of process deficiencies in nursing assessments of changes in the status of individuals. 3. Provide a summary outline of any changes in policies and procedures regarding medical care to individuals during the review period.
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Using the DMH Medical Surgical Progress Notes Auditing Form, ASH assessed its compliance based on an average sample of 21% of all individuals with at least one diagnosis on Axis III during the review period (March-August 2010). The compliance rates for the indicators

<table>
<tr><td></td><td></td><td>relevant to this requirement ranged from 99% to 100%; comparative data indicated that ASH had maintained compliance rates of at least 100% since the previous review period.

Other findings:
This monitor reviewed the Quarterly Medical Progress Notes in the charts of the following individuals: BR, BRT, BU, DXL, EDR, GP, JV, LEB, NCT, NT, RJ, TH, and TJP. These charts were selected to represent different practitioners at the facility. The review found general evidence of timely and adequate monitoring and care of the individuals by the attending Physicians and Surgeons and Family Nurse Practitioners.

Compliance:
Substantial.

Current recommendation:
Continue current practice and monitoring of this requirement.</td></tr>
<tr><td>F.7.b.ii</td><td>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</td><td>Current findings on previous recommendations:

Recommendation 1, April 2010:
Continue to monitor this requirement (Medical Transfers, Integration of Medical Conditions into the WRP and Medical Emergency Events).

Findings:
Using the DMH Medical Transfer Auditing Form, ASH assessed its compliance based on an average sample of 21% of medical transfers during the review period (March-August 2010):

<table>
<tr><td>1.</td><td>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</td><td>99%</td></tr>
<tr><td>2.</td><td>There is appropriate and timely response and</td><td>100%</td></tr>
</table>
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</table>

			documentation from the transferring physician meeting the standards of care for the condition being transferred.	
		3.	*Sufficient information is provided to the accepting facility in order to ensure continuity of care.*	88%
		4.	*Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.*	100%
		5.	*Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.*	100%
		6.	*Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.*	100%
		7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	96%

Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period for all items except item 3, which was 93% in the previous review period. However, findings regarding nursing assessments (see F.3.e and F.7.a) do not comport with the facility's compliance rate for item 1 above.

ASH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 21% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (March-August 2010). The compliance rate for the relevant indicators ranged from 98% to 100%; comparative data indicated that ASH had maintained compliance rates of at least 90%

since the previous review period.

Recommendation 2, April 2010:
Present results of medical emergency reviews on both drills and actual events.

Findings:
During this review period, the facility initiated monitoring of its medical emergency response system using the DMH Medical Emergency Response (Actual) MH-C 9128 Form. The facility assessed its compliance based on a sample of 100% of actual medical emergencies (mean number was four per month) during the review period (March to July 2010):

1.	*Did the first responder appropriately assess and call for help?*	100%
2.	*Did the first responder provide appropriate CPR procedure?*	100%
3.	*Did the first responder provide appropriate rescue breathing procedures?*	N/A
4.	*Did the first responder provide Heimlich procedure?*	N/A
5.	*Did the first responder provide appropriate BFA procedures?*	100%
6.	*Did the individual suffer any complications?*	100%
7.	*Did the RN respond in a timeframe consistent with the emergency?*	100%
8.	*Did the MD respond within 15 minutes?*	100%
9.	*Did a sufficient number of staff respond in a timeframe?*	100%
10.	*Was the unit milieu appropriately managed?*	100%
11.	*Was all required equipment available?*	100%
12.	*Was all required equipment in working order?*	100%
13.	*Were all medical supplies available?*	100%

		14.	*Were all medications available?*	100%
		15.	*Was the overall response organized in a manner that led to the best outcome for the individual?*	100%
		16.	*Did all the staff perform according to assigned roles?*	100%
		17.	*Was staff competent in operating equipment?*	100%
		18.	*Was the announcement "Code Blue" timely and clear?*	100%
		19.	*Was EMS able to access the site in a timely manner?*	100%
		20.	*Was all required documentation completed?*	100%
		21.	*Was the equipment restocking completed within 8 hours?*	100%

Comparative data were not available.

Using the DMH Medical Emergency Response (Drill) MH-C 9128 Form, the facility also assessed its compliance based on a mean 4% sample of occupied units (total of seven units) during the review period (March to August 2010):

1.	*Did the first responder appropriately assess and call for help?*	100%
2.	*Did the first responder provide appropriate CPR proc?*	100%
3.	*Did the first responder provide appropriate rescue breathing procedures?*	100%
4.	*Did the first responder provide Heimlich procedure?*	N/A
5.	*Did the first responder provide appropriate BFA procedures?*	100%
6.	*Did the individual suffer any complications?*	100%
7.	*Did the RN respond in a timeframe consistent with the emergency?*	100%
8.	*Did the MD respond within 15 minutes?*	95%
9.	*Did a sufficient number of staff respond in a timeframe?*	100%

		10.	*Was the unit milieu appropriately managed?*	83%
		11.	*Was all required equipment available?*	100%
		12.	*Was all required equipment in working order?*	100%
		13.	*Were all medical supplies available?*	100%
		14.	*Were all medications available?*	100%
		15.	*Was the overall response organized in a manner that led to the best outcome for the individual?*	100%
		16.	*Did all the staff perform according to assigned roles?*	95%
		17.	*Was staff competent in operating equipment?*	100%
		18.	*Was the announcement "Code Blue" timely and clear?*	100%
		19.	*Was EMS able to access the site in a timely manner?*	100%
		20.	*Was all required documentation completed?*	100%
		21.	*Was the equipment restocking completed within 8 hours?*	100%

Comparative data were not available.

At the request of this monitor, the facility provided information on the areas of concern identified during the performance of each drill and corresponding corrective actions. The information were adequate and is summarized as follows:

1. Unit staff unsure where stair chair located (3/30): US to train all unit staff.
2. More assertive crowd control of residents needed (3/30): Reviewed with DPS to direct residents away from scene.
3. Fluid resuscitation was insufficient (4/26): Reviewed with Department of Medicine to ensure more aggressive fluid resuscitation.
4. Nebulized albuterol should have been used (4/26): Reviewed with Department of Medicine to ensure adequate supply.
5. Float staff accompanied injured person to the urgent care center (4/26): Reviewed with HSSs to ensure that staff from individual's

		unit escort injured to the center. 6. Oxygen should be initiated for respiratory distress. (4/26): Reviewed with HSSs to ensure that staff reviews NP #101, Emergency Oxygen. 7. Staff needs to state location of emergency when speaking with Dispatch (5/27): Immediate feedback given. 8. Wheelchair brake needs to be set when transferring someone to the chair (5/27): Immediate feedback given. 9. DPS radio communication unclear if event was real or a drill (5/27): Discussed with DPS to state medical drill when announcing. 10. Oxygen amount/rate insufficient (6/24): Discussed with MOD. 11. Staff unsure of medications contained in the tray (6/24): Nursing to consider opening tray for drills or putting together drill tray. 12. Oxygen tank carried by hand to urgent care center (6/24): Appropriate carrying bag being sought. 13. Confusion at scene with no one taking charge, time lost deciding how to transport injured person– gurney or stair chair (7/29): Discussed process at Emergency Care Committee, Chief to inform Fire Department staff that personnel more experienced in transporting injured should take control. 14. Medical Emergency Flow Sheet not utilized (7/29) & (8/18): USs to discuss use of sheet and scribe assignment and review process with staff. 15. Tube used to relieve tension and vent chest (7/29) (8/18): Discussed with MOD and reviewed with all medical staff regarding use of large bore needle to quickly vent the chest (and transport can take place with EMTs). 16. Examination of lungs was somewhat delayed (7/29): Reviewed with medical staff regarding need for focused examination to be done first. 17. Skin needs to be exposed to assess for exit wound (7/29): Nursing and medical staff to ensure that exit wound checked for at scene by staff.

		18. Messages to Communication Center were not clear if injured was staff or resident (7/29): Victim to wear sign for easy identification. 19. Radio communication from Fire Department noting location (7/29): Reviewed with Fire Department Staff. 20. When identified as a drill, staff noticeably slowed down in responding (7/29): Discussed at DPS Watch & HSS Staff meetings. 21. Crime scene evidence (blood) cleaned up (7/29): Nursing, DPS to ensure preservation of scene. **Compliance:** Substantial. **Current recommendations**: 1. Continue to monitor this requirement (Medical Transfers, Integration of Medical Conditions into the WRP and Medical Emergency Events). 2. Provide summary of areas of concern that were identified during medical emergency drills and corresponding corrective actions.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** The facility has maintained its practice since the last review. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** The facility has maintained after-hours coverage by a primary care physician and a psychiatrist on-site as confirmed by a review of the on-call schedule during this reporting period. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** The facility presented data based on a 100% sample of individuals returning from outside medical treatment during the review period (March-August 2010) tracking whether required documents were received from outside consultants/hospitals within seven days of the individual's return to the facility. The mean compliance rate was 97%; comparative data indicated that the facility maintained a compliance rate of at least 90% since the previous review period. **Other findings:** This monitor's chart reviews (see F.7.a) found that in general, the discharge assessments from outside hospitals were available in the

<table>
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<td></td>
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<td>individuals' records.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
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<tr>
<td>F.7.c</td>
<td>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
ASH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 25% (diabetes mellitus), 20 % (hypertension), 32 % (dyslipidemia) and 21 % (COPD/asthma) of individuals diagnosed with these disorders during the review months (March-August 2010). Comparative data indicated that the facility has maintained compliance rates of at least 90% since the previous review period for all items. The following tables summarize the facility's data:

<u>Diabetes Mellitus</u>

<table>
<tr><td>1.</td><td>The individual has been evaluated and supporting documentation is completed at least quarterly.</td><td>100%</td></tr>
<tr><td>2.</td><td>HgbA1C was ordered quarterly.</td><td>100%</td></tr>
<tr><td>3.</td><td>The HgbA1C is equal to or less than 7%.</td><td>100%</td></tr>
<tr><td>4.</td><td>Blood sugar is monitored regularly.</td><td>100%</td></tr>
<tr><td>5.</td><td>Urinary micro albumin is monitored annually.</td><td>100%</td></tr>
<tr><td>6.</td><td>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise</td><td>100%</td></tr>
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			contraindicated.	
		7.	*The lipid profile is monitored on admission or time of diagnosis and at least annually.*	100%
		8.	*LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.*	98%
		9.	*Blood pressure is monitored weekly.*	100%
		10.	*If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.*	100%
		11.	*An eye exam by an ophthalmologist/optometrist was completed at least annually.*	98%
		12.	*Podiatry care was provided by a podiatrist at least annually.*	99%
		13.	*A dietary consultation was considered and the recommendation followed, as applicable.*	100%
		14.	*Diabetes is addressed in Focus 6 of the WRP.*	100%
		15.	*Focus 6 for Diabetes has appropriate objectives and interventions for this condition.*	100%
		Hypertension		
		1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%
		2.	*Blood pressure is monitored weekly.*	100%
		3.	*Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.*	100%
		4.	*If the individual is 40 or older, aspirin has been ordered unless contraindicated.*	100%
		5.	*Hypertension is addressed in Focus 6 of the WRP.*	100%
		6.	*Focus 6 for Hypertension has appropriate objectives and interventions.*	100%

		7.	*A dietary consult was considered and the recommendation was followed, as applicable.*	100%
		8.	*The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.*	100%
		9.	*An exercise program has been initiated.*	99%
		10.	*If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.*	100%

Dyslipidemia

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%
2.	*A lipid panel was ordered at least quarterly.*	100%
3.	*The HDL level is >40(M) or >50(F) or a plan of care is in place.*	100%
4.	*The LDL level is ≤ 130 or a plan of care is in place.*	100%
5.	*The Triglyceride level is ≤ 200 of a plan of care is in place.*	100%
6.	*Dyslipidemia is addressed in focus 6 of the WRP.*	100%
7.	*Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.*	100%
8.	*A dietary consultation was considered and the recommendation followed, as applicable.*	98%
9.	*BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.*	97%
10.	*An exercise program has been initiated.*	100%
11.	*If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have*	99%

		been considered or initiated.	

Asthma/COPD

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%
2.	*For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.*	100%
3.	*If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.*	100%
4.	*If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.*	NA%
5.	*Asthma or COPD is addressed in focus 6 of the WRP.*	100%
6.	*Focus 6 for Asthma/COPD has appropriate objectives and interventions.*	100%
7.	*The individual has been assessed for a flu vaccination.*	100%
8.	*If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.*	100%

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve	**Current findings on previous recommendations:** **Recommendation 1, April 2010:** Continue to monitor this requirement.

	outcomes.	**Findings:** The facility reported that all Physicians and Surgeons (#19) have been re-privileged within the past two years to meet facility requirement of reprivileging every two years following the first year of appointment to the medical staff. During the past year, 95% of the Physicians and Surgeons were re-privileged utilizing performance indicators that are reviewed on a quarterly basis for each Physician and Surgeon. The assessment is conducted monthly using the new Peer Review audit tool and selecting for review individuals transferred to acute hospitals for medical care. The performance indicators addressed the following areas: 1. Appropriateness of medical care provided, including referrals and transfers to the facility's medical unit or an acute hospital; 2. The timeliness of provision of medical care (within 15 minutes for emergencies, within two hours for urgent conditions, within 24 hours for routine changes in physical condition, and reasonably within specified timeframes for follow-up care); 3. Documentation of assessments that ensure continuity of care upon the transfer of individuals; 4. Record legibility; 5. Use of a SOAP format or equivalent format to document assessment of changes in the status of individuals (format includes history and subjective complaints, physical examination and findings, assessment and diagnosis, and planned treatment or interventions with appropriate rationale); 6. Lack of reasonably preventable complications in accordance with generally accepted professional standards of care; 7. Effectiveness of treatment as evidenced by documentation of therapeutic benefits from recommendations or treatment given; and 8. Timeliness of Medical Quarterly Progress Notes, Medical-Surgical consultations, and transfer/acceptance notes. The facility reported that all Physicians and Surgeons met generally

		accepted standards of care during this review period. **Recommendation 2, April 2010:** Ensure that the process and clinical outcome data are reported in alignment with the framework agreed to by the facility medical directors in December 2009. **Findings:** During this review period, ASH continued to gather both process and clinical outcome data for the current reporting period, including comparisons with the previous review period. Few additional indicators were used during this period. The following is a summary outline of the data: 1. Process outcomes tracked: a. Number of individuals newly diagnosed with Diabetes Mellitus; b. Number of new diagnoses of Diabetes Mellitus in individuals receiving new generation antipsychotics; c. Number of individuals diagnosed with Diabetes Mellitus and receiving new generation antipsychotics; d. Percentage of individuals whose BMI is tracked monthly; e. Presence of WRP Objectives and interventions for constipation; f. Number of individuals with 3+ falls in 30 days; g. Total number of falls; h. Timeliness and appropriateness of external consultations; i. Number of unexpected mortalities; and j. Review process for unexpected deaths. 2. Clinical outcomes tracked: a. Hemoglobin A1C levels in individuals diagnosed with Diabetes Mellitus; b. Hemoglobin A1C levels in individuals diagnosed with Diabetes Mellitus and receiving new generation antipsychotics;

		c. Percentage of individuals with dyslipidemia with LDL <130; d. Percentage of individuals with diabetes mellitus with LDL <100; e. Number/percentage of individuals with BMI >25; f. Percentage of individuals with hypertension with blood pressure < 140/90; g. Percentage of individuals with diabetes mellitus and blood pressure <130/80; h. Number of individuals hospitalized for bowel dysfunction; i. Individuals with falls resulting in major injury; j. Number of individuals diagnosed with aspiration pneumonia; k. Number of individuals with refractory seizures; and l. Number of individuals with status epilepticus. Some of the above-listed outcomes are reflected in the Key Indicator data presented in the appendix of this report. Review of the outcome data found that the facility has, in general, maintained positive outcomes of its medical services. The facility reported that its Medical Risk Management Committee has reviewed the process and clinical outcome data to assess overall performance. **Compliance:** Substantial. **Current recommendations**: 1. Continue to provide information regarding the facility's review of the performance of Physicians and Surgeons based on objective indicators. 2. Continue to provide process and clinical outcomes of medical service with comparison to previous review period.

8. Infection Control		
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Brandi Norico, PHN II 2. Gina M. Dusi, PHN II 3. Rosemary Morrison, RN, Acting Nurse Administrator Reviewed: 1. ASH's progress report and data 2. Infection Control Committee meeting minutes dated 4/27/10 and 5/27/10 3. HSS Committee meeting minutes for 4/12/10, 4/26/10, 5/3/10, 5/17/10, 6/21/10, 7/19/10, 8/2/10 and 8/16/10 4. Department of Medicine minutes dated 10/15/09, 11/18/09, 12/17/09, 1/21/10 and 2/18/10 5. Central Nursing Service Mentor Meeting minutes dated 6/24/10 6. Hospital Associated Infection Reports for April through July 2010 7. Environment of Care minutes dated 5/20/10, 7/15/10 and 8/19/10 8. Public Health Committee Quarterly Meeting minutes dated 8/18/2010 9. ASH's Public Health Services Outbreak Management Process 10. Public Health Services Admission Unit RN Training Outline 11. Medical records for the following 117 individuals: ACR, ACU, AEM, AES, AG, ALH, AM, AMS, AS, BBR, BDM, BRM, BRT, CCB, CJG, CPR, CT, DAP, DEG, DGP, DJG, DJW, DKS, DLB, DMG, DO, DPP, DRG, DRO, DS, DVM, DW, EMA, EWF, FLT, GLM, GMK, GV, GW, HAC, HDL, HPA, HSH, IES, JAL, JAM, JAP, JB, JBL, JC, JD, JG, JH, JJC, JJL, JJP, JKC, JLC, JM, JML, JMZ, JN, JNA, JOA, JR, JRR, JS, JWT, KBA, KDL, LDW, LJC, MAG, MB, MDC, MG, MJA, MJP, MM, MP, MPP, MTG, MVB, OC, PJC, PTR, PWZ, RC, RCH, RCV, RD, RIK, RJS, RLS, RMR, RMS, ROL, RPV, RS, RVH, SA, SAP, SBH, SC, SEE, SJP, SLS, SM, SP, SRC, TA, TEC, TH, TJO, TOH, VAN and VL

<table>
<tr><td>F.8.a</td><td>Each State hospital shall establish an effective infection control program that:</td><td>Compliance:
Substantial.</td></tr>
<tr><td>F.8.a.i</td><td>actively collects data regarding infections and communicable diseases;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings (by test/disease):

<u>Admission PPD</u>
Using the DMH IC Admission PPD Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital with a negative PPD in the review months (March-August 2010):

<table>
<tr><td>1.</td><td>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</td><td>100%</td></tr>
<tr><td>2.</td><td>PPDs were ordered by the physician during the admission procedure.</td><td>100%</td></tr>
<tr><td>3.</td><td>PPDs were administered by the nurse within 24 hours of the physicians order.</td><td>100%</td></tr>
<tr><td>4.</td><td>1st step PPDs were read by the nurse within 7 days of administration.</td><td>100%</td></tr>
<tr><td>5.</td><td>2nd step PPDs were read by the nurse within 48-72 hours of administration.</td><td>N/A</td></tr>
</table>

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items. (Regarding item 5, the facility does not use two-step PPDs.)

<u>F.8.a.ii: Assesses these data for trends</u>
No problematic trends were identified.</td></tr>
</table>

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
No corrective action was needed.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor this requirement.

A review of the records of 29 individuals admitted during the review period (AG, ALH, AMS, CCB, CJG, CPR, DJG, DO, DRG, DRO, DVM, HPA, JD, JKC, JWT, KBA, MAG, MJA, MM, MPP, RJS, RMR, SA, SBH, SM, TEC, TJO, TOH and VL) found that all had a physician's order for PPD upon admission and all were timely administered and read.

Annual PPD
Using the DMH IC Annual PPD Audit, ASH assessed its compliance based on an average sample of 20% of individuals needing an annual PPD during the review months (March-August 2010):

1.	*Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.*	100%
2.	*PPDs were ordered by the physician during the annual review procedure.*	100%
3.	*PPDs were administered by the nurse within 24 hours of the order.*	100%
4.	*PPDs were read by the nurse within 48-72 hours of administration.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
No corrective action was needed.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor this requirement.

A review of the records of 15 individuals requiring an annual PPD during the review period (AM, AS, DAP, DEG, DW, HDL, JAP, JJC, JRR, LJC, MVB, PTR, RIK, SEE and SP) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.

Hepatitis C
Using the DMH IC Hepatitis C Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital in the review months (March-August 2010) who were positive for Hepatitis C:

1.	*Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.*	100%
3.	*Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.*	100%
4.	*The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.*	100%

5.	*A Focus 6 is opened for Hepatitis C.*	100%
6.	*Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet*	100%
7.	*Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
No corrective action was needed.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor this requirement.

A review of the records of 23 individuals who were admitted Hepatitis C positive during the review period (AES, ALH, DLB, EWF, FLT, GMK, HAC, JBL, JC, JG, JJL, JJP, JML, JOA, JS, JS, MDC, MTG, PJC, PWZ, RLS, SRC and VAN) found all contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 for Hepatitis C; and all had adequate and appropriate objectives and interventions.

HIV Positive
Using the DMH IC HIV Positive Audit, ASH assessed its compliance based on a 100% sample (six individuals) of individuals who were positive for HIV antibody in the review months (March-August 2010):

		1.	*Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.*	100%
		2.	*Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.*	100%
		3.	*If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.*	100%
		4.	*If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.*	N/A
		5.	*The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.*	100%
		6.	*A Focus 6 is opened for HIV (unspecified viral illness)*	100%
		7.	*Appropriate objective is written to address the progression of the disease.*	100%
		8.	*Appropriate interventions are written.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period as well).

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
No corrective action was needed.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor this requirement.

A review of the records of six individuals who were admitted during the review period with HIV (BDM, JAL, JB, RMS, RVH and TA) found all were in compliance regarding clinic referrals and follow-up, and all WRPs contained appropriate objectives and/or interventions.

Immunizations
Using the DMH IC Immunization Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital during the review months (March-August 2010):

1.	*Notification by the lab was made to the Infection Control Department of an individual's immunity status.*	100%
2.	*Notification by the lab was made to the unit housing the individual of his/her immunity status.*	100%
3.	*Immunizations were ordered by the physician within 30 days of receiving notification by the lab.*	100%
4.	*Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
No corrective action was needed.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor this requirement.

A review of the records of 29 individuals (AG, ALH, AMS, CCB, CJG, CPR, DJG, DO, DRG, DRO, DVM, HPA, JD, JKC, JWT, KBA, MAG, MJA, MM, MPP, RJS, RMR, SA, SBH, SM, TEC, TJO, TOH and VL) found that all contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all ordered immunizations were timely administered.

Immunization Refusals
Using the DMH IC Immunization Refusal Audit, ASH assessed its compliance based on a 73% sample of individuals in the hospital who refused to take their immunizations during the review months (March-August 2010):

1.	*Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s*	100%
2.	*There is a Focus 6 opened for the refusal of the immunization(s).*	100%
3.	*There are appropriate objective(s) developed for the refusal of immunization(s).*	100%
4.	*There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).*	100%
5.	*The unit notified the Infection Control Department*	100%

	when the individual consented and received the immunization(s).	

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items (item 5 was N/A in the previous period).

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
No corrective action was needed.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor this requirement.

A review of the records of 17 individuals who refused immunizations during the review period (ACR, BBR, BRT, DGP, DJW, DPP, GLM, HSH, JAM, JH, JMZ, JNA, MJP, RC, ROL, SC and SJP) found that all WRPs contained an open Focus 6 and appropriate objectives and interventions.

MRSA
Using the DMH IC MRSA Audit, ASH assessed its compliance based on a 100% sample (13 individuals) of individuals in the hospital who tested positive for MRSA during the review months (March-August 2010):

1.	*Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.*	100%
2.	*Notification by the lab was made to the unit housing*	100%

			the individual that a positive culture for MRSA was obtained	
		3.	*The individual is placed on contact precaution per MRSA policy.*	100%
		4.	*The appropriate antibiotic was ordered for treatment of the infection(s).*	100%
		5.	*The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.*	100%
		6.	*A Focus 6 is opened for MRSA.*	100%
		7.	*Appropriate objective is written to include prevention of spread of infection*	100%
		8.	*Appropriate interventions are written to include contact precautions.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
No corrective action was needed.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor this requirement.

A review of the records of 13 individuals with MRSA (AEM, BRM, DKS, DMG, GV, IES, JR, KDL, MP, RCH, RPV, SLS and TH) found that all individuals were placed on contact precautions; all individuals were placed

on the appropriate antibiotic; and all WRPs contained appropriate objectives and interventions.

Positive PPD

Using the DMH IC Positive PPD Audit, ASH assessed its compliance based on an average sample of 100% of individuals in the hospital who had a positive PPD test during the review months (March-August 2010):

1.	*Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.*	100%
2.	*All positive PPDs received PA and Lateral Chest X-ray.*	100%
3.	*All positive PPDs received an evaluation by the Med-Surg Physician.*	100%
4.	*If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.*	N/A
5.	*If LTBI is present, there is a Focus 6 opened.*	100%
6.	*If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.*	100%
7.	*If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period as well).

F.8.a.ii: Assesses these data for trends

No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends

None required.

F.8.a.iv: Identifies necessary corrective action
No corrective action was needed.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor this requirement.

A review of the records of nine individuals who had a positive PPD (ACU, EMA, GW, JLC, JM, OC, RC, RCV and SAP) found that all individuals had the required chest x-rays; all records contained documentation of an evaluation from the physician; and all WRPs contained appropriate objectives and interventions.

Refusal of Admitting or Annual Lab Work or Diagnostic Tests
Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, ASH assessed its compliance based on a 100% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (March-August 2010):

1.	*Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.*	100%
2.	*There is a Focus opened for the lab work or PPD refusal*	100%
3.	*There are appropriate objectives written for the lab work or PPD refusal.*	100%
4.	*There are appropriate interventions written for the lab work or PPD refusal.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
No corrective action was needed.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor this requirement.

A review of the records of nine individuals who refused admitting or annual labs/diagnostics (CT, DS, GV, JN, LDW, MB, MG, RD and RS) found that all refusals were adequately addressed in the WRPs and three of the nine individuals actually decided to have the test/diagnostics.

Sexually Transmitted Diseases
Using the DMH IC Sexually Transmitted Disease (STD) Audit, ASH assessed its compliance based on an average sample of 100% of individuals (one individual) in the hospital who tested positive for an STD during the review months (March-August 2010):

1.	*Notification by the lab was made to the Infection Control Department of a positive STD.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a STD.*	100%
3.	*An RPR is ordered during the admission process for each individual.*	100%
4.	*An HIV antibody test is offered to every individual upon admission.*	100%
5.	*A Chlamydia and Gonorrhea test are ordered during*	N/A

	the admission process for all female individuals	
6.	*If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.*	N/A
7.	*Focus 6 is opened for an individual testing positive for an STD.*	100%
8.	*Appropriate objective(s) are written.*	100%
9.	*Appropriate interventions are written.*	100%

Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items (items 5 and 6 were N/A in the previous period as well).

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
No corrective action was needed.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor this requirement.

A review of the records of one individual with diagnosed STDs (JM) found that the appropriate lab work indicating a positive STD was obtained and the STD was adequately addressed in the WRP.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** See F.8.a.i. **Other findings:** ASH's key indicator data from the facility accurately reflected the infection control trends from the review period. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice.

		Findings: Review of the minutes of ASH's meetings verified that IC data are discussed at the Infection Control Committee meetings and other discipline committee meetings. Additional areas addressed by Infection Control noted in meeting minutes included: • In March 2010, collaborative efforts between IC and Plant Operations were initiated to complete changes in the Admission Suite HEPA Filtration System; • In March 2010, Public Health Services (PHS) completed Annual Report of Medical Waste Usage; • In March 2010, the Infection Control Committee approved targeted used of 70% isopropyl alcohol; • In April 2010, PHS completed Infection Control Manual audit findings; • In May 2010, Infection Control Committee approved testing employees for measles/mumps; • In May 2010, the administration initiated changes to mandated admission TSTs. Administration in collaboration with Department of Mental Health Headquarters will be proposing legislative changes to mandate admission TSTs; • In May 2010, PHS initiated annual West Nile Virus Campaign; • In May 2010, PHS implemented GIVI (Gastrointestinal Viral Illness) outbreak control measures on unit 11; • In May 2010, PHS observed trend of transferring facilities with incomplete TB surveillance information; • In May 2010, PHS presented to Administration and the Infection Control Committee members a retrospective study on admission TST and CXR information received by transferring facilities; • In June 2010, PHS implemented GIVI (Gastrointestinal Viral Illness) outbreak control measures on units 4 and 26; • In June 2010, Dental Department submitted justification to the ICC regarding dental safety syringe product review and justification of

		current products in place; • In June 2010, PHS distributed hospital-wide "Extreme Heat" information; • In July 2010, GIVI outbreak control measures implemented on multiple units impacting day to day functions hospital wide; • In July 2010, distributed respirators to employees who were previously fit trained/fit tested for use on unit 20 (outbreak unit); • In July 2010, employee notification of free pertussis vaccine availability in San Luis Obispo County; • In August 2010, continuation of GIVI outbreak control measures; • In September 2010, implementation of employee and resident 2010-2011 Influenza Campaign; • In September 2010, PHNs attended State presentation on Federal mandated HAI reporting; and • In September 2010, Infection Control met with the HSSs and presented an admission communicable disease training packet for admission RNs covering various topics such as admission TST process, admission vaccinations, admission blood-borne pathogens education, and admission HIV testing and consent. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

9. Dental Services		
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Jeff Sheppard, DDS 2. Nolan Nelson, DDS 3. Ronald Arnoldsen, DDS Reviewed: 1. ASH's progress report and data 2. ASH's dental appointment logs 3. Medical records for the following 136 individuals: AAA, AAW, AEB, AH, AJW, AM, AMM, AMS, ANM, ARL, AS, ASA, ATM, AV, AVL, AVS, BAW, BBS, BCS, BDA, BLH, BTG, CFC, CLL, CP, CPR, DAL, DAP, DCF, DEG, DLA, DO, DRO, DRS, DS, DSS, DT, DW, EC, ES, FR, GAB, GDS, GLS, GTR, HAC, HDL, HRM, JAP, JCD, JCG, JDT, JEF, JEM, JF, JFW, JG, JJC, JLG, JLM, JOB, JOS, JRR, JSR, JTC, JWT, KAC, KBS, KH, KLC, KRM, LEU, LG, LJC, LRM, LVM, MAR, MAS, ME, MFB, MJ, MKP, MPP, MPS, MS, MT, MTW, MVB, NT, ODM, OG, OGV, PA, PAB, PG, PHA, PNB, PS, PTR, RAM, RB, RDW, REC, REJ, REN, RIK, RJS, RJY, RL, RLS, RM, RMC, RMR, RP, RPM, RPO, RSC, RYS, SAG, SEE, SNL, SP, SPH, ST, TDW, TE, TJO, TT, VCI, VP, VRO, WA, WD, WJF, WRK and WTM
F.9.a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** There has been no new staff added to the ASH's Dental Department since the last review. This reviewer's findings for this section indicated that the facility has an adequate number of dentists to provide timely

<table>
<tr><td></td><td></td><td>and adequate dental care and treatment.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.9.b</td><td>Each State hospital shall develop and implement policies and procedures that require:</td><td>Compliance:
Substantial.</td></tr>
<tr><td>F.9.b.i</td><td>comprehensive and timely provision of dental services;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Dental Services Audit, ASH assessed its compliance based on a 27% mean sample of individuals scheduled for comprehensive dental exams during the review months (March-August 2010):

<table><tr><td>1.a</td><td>Comprehensive dental exam was completed</td><td>100%</td></tr></table>
Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 24 individuals (ASA, BDA, BTG, DCF, DS, DT, HRM, JCG, JEF, JEM, JG, JLG, KBS, LG, MAR, ME, MPS, MS, PG, RM, VP, VRO, WA and WTM) found all individuals received a comprehensive dental exam.

Using the DMH Dental Services Audit, ASH assessed its compliance based on a 22% mean sample of individuals who have been in the hospital</td></tr>
</table>

for 90 days or less during the review period (March-August 2010):

1.b	*If admission examination date was 90 days or less*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 24 individuals (ASA, BDA, BTG, DCF, DS, DT, HRM, JCG, JEF, JEM, JG, JLG, KBS, LG, MAR, ME, MPS, MS, PG, RM, VP, VRO, WA and WTM) found that all individuals were timely seen for their admission exams.

Using the DMH Dental Services Audit, ASH assessed its compliance based on a 20% mean sample of individuals due for annual routine dental examinations during the review months (March-August 2010):

1.c	*Annual date of examination was within anniversary month of admission*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 15 individuals (AM, AS, DAP, DEG, DW, HDL, JAP, JJC, JRR, LJC, MVB, PTR, RIK, SEE and SP) found that all annual exams were timely completed.

Using the DMH Dental Services Audit, ASH assessed its compliance based on a 25% mean sample of individuals with dental problems identified on admission or annual examination during the review months (March-August 2010):

1.d	*Individuals with identified problems on admission or annual examination receive follow up care, as*	100%

	indicated, in a timely manner	

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 39 individuals (AM, AS, ASA, BDA, BTG, DAP, DCF, DEG, DS, DT, DW, HDL, HRM, JAP, JCG, JEF, JEM, JG, JJC, JLG, JRR, KBS, LG, LJC, MAR, ME, MPS, MS, MVB, PG, PTR, RIK, RM, SEE, SP, VP, VRO, WA and WTM) found that all individuals were timely seen for follow-up care.

Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% sample of individuals with dental problems identified other than on admission or annual examination during the review months (March-August 2010):

1.e	*Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 22 individuals (AH, AMS, AVL, BAW, CFC, CPR, DO, ES, JTC, JWT, KLC, LEU, MPP, OGV, RDW, RJS, RJY, RMR, RP, SNL, TDW and TJO) found that all individuals received timely follow-up care.

Current recommendation:
Continue to monitor this requirement.

<table>
<tr>
<td>F.9.b.ii</td>
<td>documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Dental Services Audit, ASH assessed its compliance based on a 25% mean sample of individuals scheduled for follow-up dental care during the review months (March-August 2010):

<table>
<tr><td>2.</td><td>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of dental documentation for 39 individuals (AM, AS, ASA, BDA, BTG, DAP, DCF, DEG, DS, DT, DW, HDL, HRM, JAP, JCG, JEF, JEM, JG, JJC, JLG, JRR, KBS, LG, LJC, MAR, ME, MPS, MS, MVB, PG, PTR, RIK, RM, SEE, SP, VP, VRO, WA and WTM) found compliance with the documentation requirements in all cases.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.9.b.iii</td>
<td>use of preventive and restorative care whenever possible; and</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Dental Services Audit, ASH assessed its compliance</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>based on a 20% mean sample of individuals due for annual routine dental examinations during the review months (March-August 2010):

<table>
<tr><td>3.a</td><td>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 30 individuals (BCS, BLH, DAL, DCF, DRO, DSS, EC, GDS, HAC, JEM, JF, JFW, JG, JLM, KAC, KH, MAS, ME, MFB, MKP, NT, ODM, PA, PNB, RL, RLS, RPM, RSC, SPH and VCI) found that all individuals were provided preventive care.

Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% sample of individuals scheduled for Level 1 restorative care during the review months (March-August 2010):

<table>
<tr><td>3.c</td><td>Restorative care was provided including permanent or temporary restorations (fillings)</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of eight individuals (AH, AVL, CFC, ES, JTC, KLC, RP and SNL) found that all individuals received restorative care.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.9.b.iv</td>
<td>tooth extractions be used as a treatment of last resort, which, when performed, shall be</td>
<td>Current findings on previous recommendation:</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td>justified in a manner subject to clinical review.</td>
<td>Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% sample of individuals who had tooth extractions during the review months (March-August 2010):

<table>
<tr><td>4.</td><td>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 31 individuals (AAW, ARL, ATM, AVS, CP, DLA, DRS, FR, GAB, GTR, JLM, JOB, JOS, KRM, LJC, LRM, LVM, MTW, OG, PAB, PHA, RAM, RB, REJ, REN, RLS, RYS, SAG, TE, TT and WRK) found that all records were in compliance with this requirement.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.9.c</td>
<td>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>Findings:
Using the DMH Dental Services Audit, ASH assessed its compliance based on a 25% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (March-August 2010):

<table>
<tr><td>5.</td><td>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 39 individuals (AM, AS, ASA, BDA, BTG, DAP, DCF, DEG, DS, DT, DW, HDL, HRM, JAP, JCG, JEF, JEM, JG, JJC, JLG, JRR, KBS, LG, LJC, MAR, ME, MPS, MS, MVB, PG, PTR, RIK, RM, SEE, SP, VP, VRO, WA and WTM) found that all records were in compliance with the documentation requirements.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.9.d</td>
<td>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.</td>
</tr>
</table>

Findings:
Using the DMH Dental Services Audit, ASH assessed its compliance based on a 16% mean sample of individuals scheduled for dental appointments during the review months (March-August 2010):

6.a	*The individual attended the scheduled appointment*	84%

Comparative data indicated improvement from 72% in the previous review period.

The facility provided the following data on missed appointments:

Month	Refused to come to appt	Unit staff procedural problem	Transportation problem
March	61	0	0
April	41	0	0
May	38	0	0
June	74	0	0
July	53	0	0
August	78	0	0

Review of ASH's dental logs found that refusals continue to be the major reason for missed appointments; not staff or transportation issues. See F.9.e for findings regarding dental refusals.

Compliance:
Substantial.

Current recommendation:

<table>
<tr>
<td>F.9.e</td>
<td>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, April 2010:
WRPTs need to ensure that WRPs addressing refusals are individualized.

Findings:
ASH did not address this recommendation.

Recommendation 2, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% sample of individuals scheduled for but refusing to attend dental appointments during the review months (March-August 2010):

<table>
<tr><td>7.</td><td>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</td><td>91%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 23 individuals (AAA, AEB, AJW, AMM, ANM, AV, AVL, BBS, CLL, GAB, GLS, JCD, JDT, JSR, MJ, MT, PS, REC, RMC, RPO, ST, WD and WJF) found that 14 WRPs contained documentation addressing the refusal and four WRPs included an open focus with interventions addressing refusals. These findings do not comport with the facility's data. From discussions with the Standards Compliance Coordinator, the dental department was rating the risk level of individuals who refused dental appointments, and those that are rated to
</td>
</tr>
</table>

		be at high risk are to have a WRP implemented by the team. However, no dental ratings were found in the dental notes or in the WRPs reviewed for the 23 records reviewed. There was no consistent system in place at the time of the review addressing dental refusals. The facility's progress report indicated that the system for dental appointments and refusals included the following steps: • US or NOC shift lead initiates the Daily Appointment Tracking Log by identifying appointments scheduled for the day. • The AM shift lead assigns a "Follow Through Staff" (FTS) who notifies individuals who have a scheduled appointment or lab. • The FTS identifies if individual will attend appointment and documents this on the Daily Appointment Tracking log sheet. • The FTS reschedules missed appointments and notes the rescheduled date on the log. • The FTS writes an IDN for each refused or missed appointment that includes what appointment was missed/refused, the reason, and the date and time of rescheduled appointment. • Daily Appointment Tracking Log information is entered in sick call by the FTS for MD review the following day. The FTS signs the Daily Appointment Tracking Log and places it in the sick call log for the sick call RN. • The MD rates risk of possible adverse outcome regarding the refusal or missed appointment/test in the PPN. The sick call RN then documents the risk in red on tracking log. • The sick call RN signs the Daily Appointment Tracking Log and returns it to the FTS assigned for the day. • The FTS then delivers completed Daily Appointment Tracking Log to the Team Recorder. • The Team Recorder enters all missed and refused appointments into the Task Tracker and notifies the RN Sponsor via email when the refusal information has been entered into the Task Tracker. The Team Recorder then signs the Daily Appointment Tracking Log and

		returns it to the US. • The US/Designee ensures that all steps on Daily Appointment Tracking Log have been completed and signs the log. The US will then fax the completed and signed log to the Nursing Coordinator. The US will retain the Daily Appointment Tracking Log for three months. • The RN Sponsor is responsible for ensuring that the refusal is addressed in the individual's next WRP. • The Nursing Coordinator ensures that appropriate Refusal Documentation is entered into the WRP by completing a 10% real time review of WRPs prior to finalization, and a 10% spot check of finalized WRPs. • The Nursing Coordinators will notify CNS and RN Mentor if an RN is identified as requiring mentoring in regards to the quality of refusal documentation. This includes narrative in Risk Section and objectives and interventions as needed. At the time of the review, there were no formal policies or procedures in place addressing dental refusals. The facility needs to formalize this process into a written policy/procedure to ensure consistency for addressing dental refusals. **Compliance:** Partial. **Current recommendations**: 1. Formalize the process for addressing dental refusals into a written policy/procedure to ensure consistency. 2. Ensure that WRPs addressing dental refusals are individualized. 3. Continue to monitor this requirement.

G. Documentation		
G	Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.	**Summary of Progress:** Please refer to Sections D, E, F and H for judgments on the progress ASH has made towards aligning documentation practices with the requirements of the EP.

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** ASH continues to be committed to decreasing the use the restraint and seclusion and has maintained substantial compliance with all areas of Section H except in the use of prone restraints, prone containment and prone transportation, which is prohibited by the Enhancement Plan.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. David Landrum, Acting Chief of Police 1. Donna Nelson, Standards Compliance Director 2. Rosemary Morrison, RN, Acting Nurse Administrator 3. Stan Wilt, RN, Central Nursing Services <u>Reviewed</u>: 1. ASH's progress report and data 2. ASH's Prone Stabilization report 3. ASH's training rosters 4. Incident Management Review Committee minutes dated 7/15/2010 5. Medical records for the following 28 individuals: AFD, AM, AOO, AW, BSB, BTM, CDB, CPJ, DEH, DTV, ED, EGD, HEZ, JD, JKS, JLN, JV, JW, KBS, KH, ME, MJP, OLC, PNM, RAS, RE, RSD and VW
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and	**Current findings on previous recommendations:** **Recommendations 1-3, April 2010:** • Continue to collect information on and review episodes of prone stabilization/transportation. • Provide documentation of corrective action in the event that prone restraint, prone containment and/or prone transportation were used. • Continue to monitor this requirement.

	shall list the types of restraints that are acceptable for use.	**Findings:** During the review period, there was one incident of prone transport on 6/2/2010 involving one individual (DJ). The minutes of the Incident Management Review Committee (IMRC) dated 7/15/10 indicated that the incident was reviewed and that "improvement" regarding the documentation of the incident was needed. ASH's progress report indicated that the committee recommended the development of a template for Unit Supervisors and Program Management to follow to identify and address failures in compliance with prone policy; it will be added to Administrative Directive #809 under Level I and Level II reviews by management. A description of the combative and assaultive nature of the incident provided by the Acting Chief of Police from review of a video was not reflected in the documentation in the individual's record. A review of the minutes of the IMRC did not initially include the methodology of how the case was reviewed, but the methodology was added to the minutes after discussions with the Standards Compliance Coordinator while on site. In addition, there was no discussion found in the IMRC minutes addressing the problematic issues of the event including staff positioning and injuries to the individual and ways the use of prone containment/transportation could have been possibly avoided. **Compliance:** Partial due to one event of prone transportation, which is prohibited by the requirements of the Enhancement Plan. **Current recommendations**: 1. Continue to collect and review episodes of prone stabilization/ transportation. 2. Include specific methodology and address/document the resolution of problematic issues and corrective action in the IMRC minutes in the event that the prone restraints, prone containment and/or prone transportation are used.

<table>
<tr><td></td><td></td><td>3. Continue to monitor this requirement.</td></tr>
<tr><td>H.2</td><td>Each State hospital shall ensure that restraints and seclusion:</td><td>Compliance:
Substantial.</td></tr>
<tr><td>H.2.a</td><td>are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 22% mean sample of initial seclusion orders each month during the review period (March-August 2010):

<table>
<tr><td>1.</td><td>Seclusion is used in a documented manner.</td><td>100%</td></tr>
<tr><td>2.</td><td>Seclusion is used only when the individual posed an imminent danger to self or others.</td><td>100%</td></tr>
<tr><td>3.</td><td>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.

A review of 42 episodes of seclusion for 14 individuals (BSB, CDB, DEH, ED, JKS, JLN, JV, JW, KBS, KH, ME, PNM, RE and RSD) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>based on a 25% mean sample of initial restraint orders each month during the review period (March-August 2010):

<table>
<tr><td>1.</td><td>Restraint is used in a documented manner.</td><td>100%</td></tr>
<tr><td>2.</td><td>Restraint is used only when the individual posed an imminent danger to self or others.</td><td>100%</td></tr>
<tr><td>3.</td><td>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</td><td>99%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.

A review of 42 episodes of restraint for 16 individuals (AFD, AM, AOO, AW, BTM, CPJ, DTV, EGD, HEZ, JVW, KH, MJP, OLC, PMN, RAS and RE) found that the documentation for all episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>H.2.b</td>
<td>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 22% mean sample of initial seclusion orders each month during the review period (March-August 2010):</td>
</tr>
</table>

		4.	*Seclusion is not used in the absence of, or as an alternative to, active treatment.*	100%
		5.	*The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].*	100%
		6.	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.

A review of 42 episodes of seclusion for 14 individuals (BSB, CDB, DEH, ED, JKS, JLN, JV, JW, KBS, KH, ME, PNM, RE and RSD) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in 40 episodes indicated that the individual was released when calm.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 25% mean sample of initial restraint orders each month during the review period (March-August 2010):

4.	*Restraint is not used in the absence of, or as an alternative to, active treatment.*	100%
5.	*The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was*	100%

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		calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].	
		6.	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.*	100%

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.

A review of 42 episodes of restraint for 16 individuals (AFD, AM, AOO, AW, BTM, CPJ, DTV, EGD, HEZ, JVW, KH, MJP, OLC, PMN, RAS and RE) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm

Current recommendation:
Continue to monitor this requirement.

H.2.c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** See F.2.c.iv. **Findings:** See F.2.c.iv. **Current recommendations**: See F.2.c.iv.

<table>
<tr>
<td>H.2.d</td>
<td>are terminated as soon as the individual is no longer an imminent danger to self or others.</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 22% mean sample of episodes of seclusion each month during the review period (March-August 2010):

<table>
<tr><td>7.</td><td>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

See H.2.b for review findings.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 25% mean sample of episodes of restraint each month during the review period (March-August 2010):

<table>
<tr><td>7.</td><td>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</td><td>100%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

See H.2.b for review findings.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
</table>

<table>
<tr>
<td>H.3</td>
<td>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</td>
<td>
Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 22% mean sample of initial seclusion orders each month during the review period (March-August 2010):

<table>
<tr><td>8.</td><td>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.</td><td>98%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of 42 episodes of seclusion for 14 individuals (BSB, CDB, DEH, ED, JKS, JLN, JV, JW, KBS, KH, ME, PNM, RE and RSD) found that the RN conducted a timely assessment in 40 episodes and that the individual was timely seen by a psychiatrist in 40 episodes.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 25% mean sample of initial restraint orders each month during the review period (March-August 2010):

<table>
<tr><td>8.</td><td>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in restraint within one hour.</td><td>97%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at
</td>
</tr>
</table>

		least 90% from the previous review period. A review of 42 episodes of restraint for 16 individuals (AFD, AM, AOO, AW, BTM, CPJ, DTV, EGD, HEZ, JVW, KH, MJP, OLC, PMN, RAS and RE) found that the RN conducted a timely assessment in 41 episodes and that the individual was timely seen by a psychiatrist in 40 episodes. ASH's training rosters indicated that 92% of staff that was required to attend the Annual TSI (Therapeutic Strategies and Interventions) Training attended and passed. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** Since the last review, ASH continues to have the Standards Compliance Department compare the ORYX and PLATO data regarding restraint and seclusion monthly to ensure accuracy. In the event a discrepancy is found, the Department notifies the specific Program and the data are checked against the Program's raw data. The NOC shift also conducts nightly audits of the MARs and compares the PRN/Stat data to the data contained in the QuickHits database. Also, the Ongoing Enhancement Plan Performance Improvement teams review the PLATO results for Restraint/Seclusion and PRN/Stat medications monthly and initiate QI process for any developing trends.

<table>
<tr><td></td><td></td><td>A review of the PRN/Stat medications and seclusion and restraints lists provided found no incidents that were not included in the ASH databases.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>H.5</td><td>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to monitor this requirement.

Findings:
Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 93% sample of individuals who were in seclusion more than three times in 30 days during the review period (March-August 2010):

<table>
<tr><td>9.</td><td>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</td><td>94%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 14 individuals who were in seclusion more than three times in 30 days during the review period (BSB, CDB, DEH, ED, JKS, JLN, JV, JW, KBS, KH, ME, PNM, RE and RSD) found that 13 WRPs</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>included documentation within three business days.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 84% sample of individuals who were in restraint more than three times in 30 days during the review period (March-August 2010):

<table>
<tr><td>9.</td><td>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</td><td>90%</td></tr>
</table>

Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 10 individuals who were in restraint more than three times in 30 days during the review period (AFD, AW, CPJ, JVW, KH, MJP, OLC, PMN, RAS and RE) found that all WRPs included documentation within three business days.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>H.6</td>
<td>Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:</td>
<td>Compliance:
Substantial.</td>
</tr>
</table>

H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	**Current findings on previous recommendation:** **Recommendation, April 2010:** See F.1.b. **Findings:** See F.1.b. **Current recommendation:** See F.1.b.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	**Current findings on previous recommendation:** **Recommendation, April 2010:** See F.1.b. **Findings:** See F.1.b. **Current recommendation:** See F.1.b.
H.6.c	PRN medications are appropriately time limited.	**Current findings on previous recommendation:** **Recommendation, April 2010:** See F.1.b. **Findings:** See F.1.b. **Current recommendation:** See F.1.b.

H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendation:** **Recommendation, April 2010:** See F.3.a.iii. **Findings:** See F.3.a.iii. **Current recommendations:** See F.3.a.iii.
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Same as in D.1.f, F.1.b and H.6.a. **Findings:** Same as in D.1.f, F.1.b and H.6.a **Current recommendations:** Same as in D.1.f, F.1.b and H.6.a.
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendation:** **Recommendation, April 2010:** See F.3.h.i. and H.3 **Findings:** See F.3.h.i. and H.3 **Compliance:** Substantial.

		Current recommendations: See F.3.h.i and H.3.
H.8	Each State hospital shall:	**Compliance:** Not applicable.
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to monitor this requirement. **Findings:** Side rails are no longer used at ASH. **Current recommendation**: None required.
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	**Current findings on previous recommendation:** **Recommendation, April 2010:** See H.8.a. **Findings:** See H.8.a. **Current recommendation**: See H.8.a.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. With the help of nine retired annuitants, ASH is completing A/N/E investigations within the EP timeframes. 2. The facility has agreed to discontinue the use of the form wherein the treating psychiatrist makes a determination regarding the veracity of an individual's allegation. 3. The facility has augmented its Risk Management System with the addition of a Risk Management Committee that will include the chairs of the second-level committees, the IMRC, the Hospital Advisory Committee, the Peaceful Resolution Committee and the Violence Risk Management Committee. Among the goals of the new committee will be the identification of individuals who should be reviewed by the Facility Review Committee and forwarding to the Quality Council of insights/data/questions for consideration. The first meeting of this committee is scheduled for November. 4. The Standards Compliance Department has assigned a SC staff member to each Program. This staff member will attend the PRC, take minutes and work with the senior clinicians in implementing the recommendations. This is a wise use of resources designed to strengthen the first levels of review of risk situations. 5. The facility is committing considerable resources to the collection of data on violence, the analysis of this data, and the development of initiatives aimed at improving the safety of individuals in the facility and the quality of life of individuals in care. 6. In most of the sample reviewed, ASH successfully implemented that portion of the Risk Management System that requires WRPTs to address the high risk status of individuals for medical and behavioral conditions. Additionally, the recommendations of second- and third-level RM reviews were implemented or acknowledged with a rationale for not implementing them in most of the recommendations sampled. 7. DMH has issued guidance to all facilities on procedures for removing

		staff members named in A/N/E incidents. 8. The facility remains highly effective in meeting the needs of individuals with the problem of incontinence. 9. The facility reports that the bathroom refurbishing is 75% completed. The tall uprights between stalls have been removed, the partitions strengthened, piano hinges installed, and gaps between stalls and the wall have been eliminated. These improvements were observed during tours of the units.
1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. A. Alvarez, Lead Investigator 2. C. Williams, Standards Compliance 3. D. Karas, Program Director 4. D. Landrum, Hospital Administrative Resident II 5. Lt. D. Landrum, Acting Chief of Police 6. D. Nelson, Standards Compliance Director 7. J. Deane, MD, Acting Chief of Psychiatry 8. J. DeMorales, Executive Director 9. L. Persons, Hospital Administrator <u>Reviewed</u>: 1. Twelve A/N/E investigation reports 2. IMRC minutes for the review period 3. IMRC task tracking documents 4. Documents related to the death of one individual 5. Selected personnel information for 16 staff members 6. Statement of rights forms for 12individuals 7. Revised AD 518: Restraint or Seclusion and AD 512: Suicide/Self-Harm Prevention 8. OSI listing of individuals and staff members named in A/N/E allegations

I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Substantial.
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Ensure that the facility responds to all staff members who fail to report A/N/E allegations. **Findings:** Please see findings in I.1.c. Two staff members who failed to report allegations of A/N/E in the investigations reviewed received counseling. The facility reports that during the review period, there were 13 instances in which staff failed to report an allegation in the manner required by policy. **Current recommendation**: Continue current practice and vigilant monitoring of failure to report A/N/E allegations in the manner required by policy.
I.1.a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** The facility is requesting the expert opinion of the Chief of Psychiatry in incidents alleging psychological abuse. Dr. Deane has agreed to apply the definition of psychological abuse in SO 263 in rendering his opinion as to whether the actions in question constituted psychological abuse. All parties

		to this conversation recognized that the DMH definition is not the same as the legal definition of psychological abuse. **Other findings:** In the review of sexual incidents, there was no confusion between sexual abuse, sexual assault, sexual contact between adults (unwanted) and consensual sexual contact. In each instance, the coding of the incident was correct. **Current recommendation**: As agreed, apply the SO 263 definitions of psychological abuse in making determinations.
I.1.a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Implement the DMH guidance document when it becomes available. **Findings:** DMH guidance on procedures for removing a staff member named as the alleged perpetrator in an A/N/E incident was recently provided in SO 263. At the time of this review, ASH had not had sufficient time to implement it. **Other findings:** In one of the 11 investigations reviewed, the named staff member was removed. Several investigations noted that the decision to remove or not was made in consultation with the Clinical Administrator. In other investigations, however, only the Acting Chief of Police is cited as the decision-maker. Often, the rationale for the decision not to remove the named staff member was that he/she did not pose an imminent threat to the individual involved in the incident or simply that the incident did not warrant the removal of the staff member. There is no documentation of consideration of the safety of other individuals on the unit. The

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<td>investigation reports note that should the investigation uncover material that would effect this decision, it would be revisited. See also I.3.d for a description of sexual incidents in which the individuals involved were separated to avoid a recurrence.

Current recommendation:
Comply with the procedures specified in SO 263 for removing staff members named in A/N/E incidents.</td>
</tr>
<tr>
<td>I.1.a.iv</td>
<td>adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue to ensure that staff members receive annual A/N training in a timely fashion.

Findings:
The facility reports that presently 91% of the staff are current in A/N/E annual training.

Other findings:
As shown below, one of the 16 staff members sampled was overdue in attending A/N training.

<table>
<tr><td></td><td colspan="4">Date of:</td></tr>
<tr><td>Staff member*</td><td>Hire</td><td>Background clearance</td><td>Signing of Mandatory Reporter</td><td>Most recent A/N training</td></tr>
<tr><td>_A</td><td>10/19/81</td><td>10/19/81</td><td>10/27/86</td><td>9/15/10</td></tr>
<tr><td>_R</td><td>10/1/01 & 4/1/03</td><td>7/31/01</td><td>4/1/03</td><td>9/15/10</td></tr>
<tr><td>_G</td><td>1/23/06</td><td>11/1/05</td><td>1/23/06</td><td>9/15/10</td></tr>
<tr><td>_G</td><td>1/22/08</td><td>7/23/07</td><td>12/3/07</td><td>9/10/10</td></tr>
<tr><td>_S</td><td>1/26/04</td><td>11/17/03</td><td>1/26/04</td><td>9/9/10</td></tr>
</table>
</td>
</tr>
</table>

		_G | 7/6/04 & 7/6/09 | 6/17/04 | 8/10/09 | 6/15/10 _D | 3/25/02 | 6/25/01 | 3/25/02 | 6/15/10 _W | 7/2/01 | 5/5/01 | 7/2/01 | 6/2/10 _M | 10/10/89 | 10/10/89 | 10/10/89 | 5/15/10 _S | 9/24/07 | 7/20/07 | 9/24/07 | 4/9/10 _M | 12/4/89 | 12/4/89 | 12/4/89 | 4/5/10 _B | 1/21/09 | 10/16/09 | 10/07/10 | 3/17/10 _Y | 11/3/08 | 9/19/08 | 9/8/08 | 2/5/10 _L | 5/4/09 | 3/25/09 | 3/16/09 | 2/1/10 _S | 9/4/07 | 6/19/07 | 9/24/07 | 11/16/09 _M | 12/9/02 | 7/1/02 | 12/9/02 | 06/08/09 *Only last initials are provided to protect confidentiality. **Current recommendation**: Continue current practice.
I.1.a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Follow principles of progressive discipline in addressing failure to report allegations of A/N/E. Ensure that no incident of failure to report receives no response. **Findings:** In the investigations reviewed, there were no instances of staff members determined to have failed to report an allegation of A/N/E as per policy in which counseling was not provided. See I.1.c. **Other findings:** Please see the table in I.1.a.iv showing that four staff members did not sign the acknowledgement of mandatory reporter status prior or on the date of hire. Two of the four signed approximately a month after hire and the third

<table>
<tr><td></td><td></td><td>was hired nearly 30 years ago. The fourth staff member was hired in January 2009, but did not sign until October 2010. The facility reports that it monitors all newly hired employees to ensure they sign the form during the hiring process.

Current recommendation:
Continue current practice and monitoring.</td></tr>
<tr><td>I.1.a.vi</td><td>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.

Findings:
As shown below, all 12 individuals sampled were provided the opportunity to sign the statement of rights within the last 12 months:

<table>
<tr><th>Individual</th><th>Date of most recent signing</th></tr>
<tr><td>OQ</td><td>Refused</td></tr>
<tr><td>TK</td><td>1/11/10</td></tr>
<tr><td>JB</td><td>3/8/10</td></tr>
<tr><td>RG</td><td>6/4/10</td></tr>
<tr><td>WH</td><td>7/12/10</td></tr>
<tr><td>AT</td><td>8/10/10</td></tr>
<tr><td>WW</td><td>9/20/10</td></tr>
<tr><td>CG</td><td>9/29/10</td></tr>
<tr><td>BH</td><td>10/5/10</td></tr>
<tr><td>SP</td><td>10/15/10</td></tr>
<tr><td>PT</td><td>10/18/10</td></tr>
<tr><td>RL</td><td>10/19/10</td></tr>
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</td></tr>
</table>

		Current recommendation: Continue current practice.
I.1.a. vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** The units visited displayed the Rights Poster in a common area. This is consistent with the facility's finding that all of the 43 living and program areas reviewed during the review period had the Rights Poster displayed. **Current recommendation**: Continue current practice.
I.1.a. viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** In the sample of investigations reviewed, two cases were forwarded to the local District Attorney: the 5/23/10 allegation of physical abuse of LB and the 3/4/10 allegation of physical abuse of JW. **Current recommendation**: Continue current practice.
I.1.a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action,	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice of asking about threats of retaliation and bribes

	including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	when circumstances suggest these may have occurred, e.g., when an individual recants an allegation or speaks about not wanting to get a staff member in trouble. **Findings:** In the investigations sampled, there were no circumstances that suggested retaliation, fear of retaliation, or bribes to not speak up on the part of individuals in reporting allegations of A/N/E. **Current recommendation**: Continue current practice of asking about threats of retaliation and bribes when circumstances suggest these may have occurred, e.g., when an individual recants an allegation or speaks about not wanting to get a staff member in trouble.
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial. The facility's practice during the review period of asking the individual's psychiatrist to sign a form checking yes or no to the question "Is the allegation a result of the resident's mental illness?" prior to the completion of the investigation in instances in which the allegation is plausible violates standards procedures. See I.1.b.iv. The facility has agreed to discontinue the use of this form.
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with	**Current findings on previous recommendation:** **Recommendation, April 2010:** Ensure follow-up of recommendations made during Internal and External death reviews. **Findings:** One individual in care died during the review period: DM died on 6/15/10 at

	persons with mental disorders;	the San Diego Hospice. He was discharged from ASH to the hospice facility on May 31, 2010. The death was reviewed by the MIRC on 6/29/10 and the committee concluded that DM's death "was due to a known cause, for which he received appropriate medical and psychological care." **Other findings:** The Standards Compliance Director sent a memorandum to the members of the MIRC to bring to their attention the recommendations made by the Outside Evaluator for improving the MIRC process. **Current recommendation**: Continue to implement SO 205.05: Mortality Review
I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** Only OSI staff members investigate allegations of A/N/E. Investigations of criminal matters are conducted by criminal investigators in DPS. **Current recommendation**: Continue current practice.
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** There is evidence in the investigation reports reviewed of OSI's vigilance in safeguarding evidence. Specifically, the tapes from recorded interviews are

		stored safely. In the investigation of the physical abuse allegation of DJ, the videotape of the incident was preserved and still photos made to assist in the identification of the staff members involved. **Current recommendation**: Continue current practice.
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** One investigation report reviewed included a procedure that is seriously problematic. In the investigation of the allegation of verbal abuse of JS, the individual stated that staff called him a derogatory name. The report notes that there were six staff members present who possibly witnessed the incident. The report further states that only one of these staff members was interviewed. The other five were not "due to [the psychiatrist] stating the allegation is part of [the individual's] mental illness and there are previous/similar allegations in his record." This action violates standard procedure, which requires that all witnesses be interviewed, unless it is impossible to do so. Cutting the investigation short raises the question as to whether the interviews that were not conducted would have impacted the final determination. Additionally, the practice of requesting the treating psychiatrist to indicate by checking a box whether a plausible allegation under review is the result of the individual's mental illness presents the psychiatrist with an impossible task of determining the veracity of a particular statement and raises ethical questions for the psychiatrist. The facility agreed to reopen this investigation. **Current recommendations**: 1. Protect the integrity of investigations by ensuring that all witnesses are

<table>
<tr><td></td><td></td><td>interviewed.
2. As agreed, discontinue the use of the form wherein the psychiatrist makes a determination as to the veracity of an allegation.</td></tr>
<tr><td>I.1.b. iv.1</td><td>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.

Findings:
The hospital police responded quickly to the incidents reviewed—often within hours of the report of the incident.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>I.1.b. iv.2</td><td>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.

Findings:
The facility reports that all of the investigations due to be closed within the review period met the 30 business day + 5 time period.

<table>
<tr><th>Allegation Type</th><th>Date incident reported</th><th>Date to OSI</th><th>Date closed</th></tr>
<tr><td>Neglect</td><td>3/3/10</td><td>3/9/10</td><td>3/29/10</td></tr>
<tr><td>Neglect</td><td>3/22/10</td><td>3/25/10</td><td>5/24/10 N</td></tr>
<tr><td>Physical Abuse</td><td>5/23/10</td><td>5/28/10</td><td>6/17/10</td></tr>
<tr><td>Verbal Abuse</td><td>3/25/10</td><td>4/7/10</td><td>5/5/10</td></tr>
<tr><td>Neglect</td><td>4/12/10</td><td>4/15/10</td><td>5/26/10</td></tr>
<tr><td>Verbal Abuse</td><td>4/16/10</td><td>4/20/10</td><td>5/5/10</td></tr>
</table>
</td></tr>
</table>

		<table><tr><td>Verbal Abuse</td><td>4/5/10</td><td>4/8/10</td><td>5/8/10</td></tr><tr><td>Psychological Abuse</td><td>6/24/10</td><td>7/7/10</td><td>8/17/10 N</td></tr><tr><td>Physical Abuse</td><td>6/2/10</td><td>6/17/10</td><td>7/20/10 N</td></tr><tr><td>Neglect</td><td>4/13/10</td><td>4/16/10</td><td>6/11/10 N</td></tr><tr><td>Verbal Abuse</td><td>5/26/10</td><td>5/27/10 (reassigned 6/3)</td><td>7/6/10</td></tr><tr><td>Physical Abuse</td><td>7/14/10</td><td>7/29/10</td><td>8/17/10</td></tr></table> Four of 12 investigations (marked with N in far right column) reviewed did NOT close within the 30 business day timeframe of the EP. Two were late due to the unavailability of witnesses, but closed within five days of the last interview. A listing of open cases documents 23 open OSI cases as of October 18. The incident dates for the oldest of the open cases is August 2010. **Current recommendation**: Continue current practice and monitoring.
I.1.b. iv.3	each investigation results in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:	**Current findings on previous recommendation:** **Recommendation, April 2010:** As recommended previously, match the salient facts of the investigation to the definition of the type of incident under review to ensure that findings support determinations. **Findings:** The facts uncovered do not sufficiently support the determination in the investigation of the allegation of neglect of RT (3/3/10). Specifically, a staff member alleged that he saw another staff member providing 1:1 observation of RT permit RT to enter the restroom, close the door, and the staff member then looked away from the window--violating the line of sight rule. The reporting staff member noted that RT was on enhanced

		supervision following a serious self-harm attempt and should have been watched closely in the restroom. The named staff member denied losing visual contact with RT. The reporting staff member was interviewed a second time and walked the investigator down the hall to demonstrate his position and that of the named staff. RT could not say whether he was left alone in the restroom without the staff member watching through the window. The investigation notes that the Program Assistant believes the reporting party was influenced to come forward by another incident, of which no date or description or relevance is provided in the investigation. The allegation of neglect was determined not sustained, with the statement "[The reporting party] believes RT was left unattended for a time, there is no way to verify this allegation without supporting testimony or evidence." With no other witnesses to the event and required to make the determination on the preponderance of the evidence, the investigator should have included consideration of the motives of two staff members. If there were additional elements to bolster the rationale for the determination, then these should have been provided. Simply to not substantiate an allegation because no one else witnessed the event is not sufficient. **Current recommendation**: Ensure rationales provide sufficient justification for determinations.
I.1.b. iv.3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice, including self-monitoring as indicated. **Findings:** JS alleged that he went to staff for help with a medical issue, staff refused to help him and staff walked down the hall, told him to wet on himself and called him a derogatory name. The investigation focused on the verbal abuse, but did not address the allegation of neglect. The verbal abuse

		allegation was not substantiated based on the form completed by the psychiatrist stating that the allegation was a result of the individual's mental illness. The investigation is silent on a determination regarding the neglect allegation. **Current recommendation**: When more than one allegation is embedded in a case, ensure that the investigation covers each allegation and provides a determination on each.
I.1.b. iv.3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** The names of all witnesses were provided in the investigation reports reviewed. In one investigation, all identified witnesses were not interviewed; see I.1.b.iv. This investigation was an exception. **Current recommendation**: Continue current practice.
I.1.b. iv.3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** All the investigations reviewed clearly identified the alleged victim and perpetrator. **Current recommendation**: Continue current practice.

I.1.b. iv.3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** In the investigation of the allegation of neglect of RT, the investigator took extra efforts in interviewing parties to the incident. Specifically, RT was discharged before the investigation was completed. The investigator conducted a phone interview with the individual at his present site. In that same investigation, the staff member who was the reporting party was interviewed a second time to clarify his position/location and that of the named staff member at the time of the incident. **Current recommendation**: Continue current practice.
I.1.b. iv.3(v)	a summary of each interview;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** In all of the investigations reviewed, a summary of all of the interviews conducted was provided in the investigation reports. **Current recommendation**: Continue current practice.
I.1.b. iv.3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice.

		Findings: Each of the investigation reports reviewed included a list of documents referenced during the investigation. **Current recommendation**: Continue current practice.
I.1.b. iv.3 (vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Current findings on previous recommendation:** **Recommendation, April 2010:** Using the same process, add a review of the alleged victim's investigation history to the review of the staff member's investigation history. **Findings:** Review of prior incidents in which the named staff member and the alleged victim were figures occurs at the IMRC meeting. It is rarely mentioned in investigation reports. The exception in the investigations reviewed occurred in the investigation of the alleged neglect of RJ. The investigation report notes that the named staff member had "no prior incidents of neglect regarding the failure to conduct an assessment of a resident's medical procedure." This is clearly too limited a focus for the review of a staff member's involvement in prior incidents. **Other findings:** Prior to the July 29 IMRC minutes, only the incident history of the staff member was reviewed. Beginning with the August 5 meeting, the incident history (with determinations) of the victim is reviewed. **Current recommendation**: Continue current practice.

I.1.b. iv.3 (viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Match the determination with elements of the SIR definition of the incident type under review. Consider both verbal and psychological abuse in all cases in which one of these is the identified incident type. **Findings:** See I.1.a.ii for the procedures that will be used in cases involving psychological abuse. **Other findings:** In several of the investigations reviewed, investigators identified violations of hospital policies and procedures. For example, in the investigation of the allegation of neglect of RJ, the named staff member was found to have violated Nursing Procedure 218.0, AD 531: Provision of Medical Care, AD 533: Registered Nurse and Physician Communication, AD 537: Change of Shift Report, Government Code 19572 for dishonesty and other policies for his insubordination and willful disobedience. **Current recommendation**: Continue current practice of identifying failures to follow hospital policies and procedures in investigations.
I.1.b. iv.3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue the careful review of investigation reports by supervisors and the second review by the Hospital Administrative Resident. **Findings:** This recommendation has continued a multi-level review process. See the cell below.

		Other findings: In the investigation of the physical abuse of DJ on 6/2/10, the named staff member admitted to placing his knee on the back of DJ's head during a take-down event. The videotape of the event also showed the named staff member's knee on the back of DJ's head as he was contained on the floor. The investigator asked the TSI trainer, as a subject matter expert, if this was an approved technique. The trainer advised that this was not an approved technique and that staff are taught to use their hands to stabilize an individual's head. The trainer then softened her response, saying this event was an emergency and not the classroom. The investigator found the allegation of physical abuse not substantiated with the conclusion that "while not perfect or ideal, [the named staff member's] actions contributed substantially to the safe containment of the resident and prevented greater injury to the resident or staff." One might reasonably question whether there is not an expectation that the TSI techniques taught in the classroom will be used on the units when emergency measures are necessary and why this was not discussed with the trainer. One might also question why the trainer was not questioned about the risks of the maneuver. Finally, the investigator's characterization of the knee-to-head position as less than "ideal or perfect" appears to minimize this violation of accepted procedures. These questions were not raised in any of the reviews of this investigation. **Current recommendation**: Ensure that conclusions accurately represent the facts established during the investigation.
I.1.b. iv.4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Maintain vigilance in reviewing investigations and the accompanying forms

	that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.	and letters. **Findings:** The facility reports a multi-layered procedure for the review of investigations. Completed investigations are reviewed by the Lead Investigator, then by a DPS staff member who previously did criminal investigations and then by the Hospital Administrative Resident II who has been reviewing the investigations for several years. When an investigation is found satisfactory at the conclusion of this process, it is ready for review by the IMRC. **Other findings:** Review of the IMRC minutes for the review period found no reference to questions or concerns raised about the quality or completeness of any investigation. **Current recommendation**: Ensure that any issues/questions that the IMRC raises are documented in the minutes along with the response, in subsequent minutes if necessary.
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendations:** **Recommendation 1, April 2010:** Continue current practice, including self-monitoring. **Findings:** During the IMRC meeting on March 4, 2010, it was determined that two ADs did not provide sufficient clear direction for staff. Subsequently, AD 512 was amended to provide guidance on staff responsibilities when observing an individual 1:1. It requires that the staff member actively engage the individual in a therapeutic manner when the individual is awake and be aware of his plan of care and risks. Further, it prohibits staff from reading books, working puzzles, playing hand-held games and engaging in other activities

		that are incompatible with proper vigilance. AD 518 will be reviewed during the last week in October. It defines 1:1 and 2:1 observation, Line of Sight observation, and Medical 1:1 and 2:1. **Recommendation 2, April 2010:** Determine if there is a problem in HR not receiving documentation of counseling or not taking action regarding discipline when these have been recommended in investigations and by the IRC. Take appropriate action to remedy the problem. **Findings:** In the investigations reviewed, the following disciplinary actions were taken, as reported by the Human Resource Department. • In a sustained case of neglect (3/23/10), the named staff member was provided verbal instruction on the policy describing observation levels and responsibilities and received written counseling in August 2010. • In a sustained case of neglect (4/12/10) followed by a sustained neglect determination in another incident on 4/13/10, the named staff member received a pay reduction for 12 months. • Following the sustained case of verbal abuse (4/5/10) followed by a sustained case of neglect (5/21/10), the named staff member was terminated in September. • Following the sustained case of verbal and psychological abuse (6/24/10) and other policy violations, the named staff member was terminated in August. • In the sustained case of neglect (4/13/10), the named staff member was provided written counseling in July. • Failure to report per policy in an April allegation of neglect resulted in a letter of instruction to the named staff member in August. • Failure to report per policy in another April allegation of neglect resulted in a letter of expectation in October and the requirement to read and sign the relevant policy. The delay was caused by the Notice of

		Sustained Findings not being submitted to HR. In response to incidents that uncovered systemic issues, the facility took action as described below. • When it was discovered that staff members were conducting 1:1 observation of individuals whom they could not see because of the positioning of partitions in the bedroom, the partitions and beds were repositioned to provide a clear view of all of the beds in the room while maintaining the same level of privacy for individuals in each of the beds. The repositioning made it unnecessary for staff to enter the dorm, which created a safety hazard for staff, and also eliminated blind spots, a safety hazard for individuals. The proposal was presented and adopted at the June 8 Quality Council meeting. • The facility conducted a review of falls, slips and trips for the period July 2008-December2009 that was presented to the Quality Council in March 2010. The report noted that 199 unique individuals fell during that period. Individuals 50-57 years of age accounted for nearly 30% of the falls. For the 104 falls for which the cause could be determined, slightly more than half (55) were the result of wet floors. Hallways were the scene of the greatest number of these. • Medical causes accounted for 190 falls for a total for the 18-month period of 294 falls, slips and trips. **Compliance:** Substantial. **Current recommendation**: Continue current practice and monitoring of the timely and effective person-specific and systemic corrective actions resulting from incidents and performance improvement studies.

<table>
<tr><td>I.1.d</td><td>Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:</td><td>Compliance:
Substantial.</td></tr>
<tr><td>I.1.d.i</td><td>type of incident;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice, including periodic analysis of incident and trigger data.

Findings:
As listed in the DPS Incident Case Query, there were 70 incident reports alleging abuse, neglect or failure to follow procedures during the review period.

<table>
<tr><td>Abuse type</td><td>3/1-8/31/10</td></tr>
<tr><td>Abuse (physical, verbal, psychological not distinguished)</td><td>48</td></tr>
<tr><td>Sexual abuse</td><td>5</td></tr>
<tr><td>Neglect</td><td>14</td></tr>
<tr><td>Failure to follow procedures</td><td>3</td></tr>
<tr><td>Total</td><td>70</td></tr>
</table>

The number of unique individuals making allegations of A/N/E is as follows: March=15, April=10, May=8, June=11, July=7, August=19.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>I.1.d.ii</td><td>staff involved and staff present;</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.</td></tr>
</table>

		Findings: The facility produces a monthly listing of staff members named in A/N/E cases as perpetrators. This report is reviewed by the IMRC once during each six-month review period. At the IMRC, information regarding the numbers and types of incidents the named staff members have been involved in is presented for each case reviewed. **Current recommendation**: Continue current practice and document the IMRC review in the minutes.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** The facility produces a list each month of individuals listed as complainants (victims) in A/N/E cases. As stated above, this report is reviewed by the IMRC for the period covering six months. The number of times an individual has been named as the complainant in an investigation is presented to the IMRC when an investigation involving that individual is reviewed. **Current recommendation**: Continue current practice and document the IMRC review in the minutes.
I.1.d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** The facility's data provides the number of incidents of aggression for each

		unit in the facility during the period March-August 2010. Totals by Program are presented below with the number in brackets presenting the number that occurred on the admissions units in that Program. Admissions units saw the highest number of incidents of aggression. Program 1: 207 (individuals with 1370 commitments) [81] Program 3: 111 [23] Program 5: 71 [27] Program 6: 111 [65] Program 7: 122 [47] **Current recommendation**: Continue current practice of monitoring the location of incidents.
I.1.d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice of presenting data with thoughtful analysis. **Findings:** Incidents of aggression were more likely to occur on the PM shift during the review period, according to facility data. Specifically, in the five Programs, the PM shift accounted for 49%-55% of the total aggressive incidents. **Current recommendation**: Continue current practice of presenting data with analysis and where appropriate the implication of the findings.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice.

		Findings: The facility is working to improve the unit reviews and PRM review of incidents to include any contributing factors. These same factors are also included in HQ briefs. See also I.2.a.iii and I.2.c for descriptions of ASH's work in identifying factors contributing to hospital violence. **Current recommendation**: Continue current practice and monitoring.
I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice, including analysis of substantiation rate. **Findings:** Review of the RMS report of A/N/E incidents for the review period finds that seven staff members were named in sustained cases of verbal abuse, eleven in sustained cases of neglect, and nine in sustained cases of policy violations. **Current recommendation**: Continue current practice, include analysis of substantiation rate.
I.1.e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly	**Current findings on previous recommendations:** **Recommendation 1, April 2010:** Continue current practice as related to background checks. **Findings:** As presented in the table in I.1.a.iv, all of the sampled staff members had cleared background checks prior to their date of hire.

	supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.	**Recommendation 2, April 2010:** Follow DMH guidance in applying a consistent system across facilities for determining when to remove a staff member named in an A/N/E allegation. **Findings:** SO 263, provided to the facilities in October 2010, provides guidance for removing alleged perpetrators from direct contact with the individuals involved in an incident. Specifically, it states that the Program Director is responsible for removing all alleged perpetrators of physical abuse from direct contact with individuals. In those instances, however, when the allegation appears to be physically impossible or otherwise lacks credibility, the Program Director may refer the case for administrative review by a member of senior management with the goal of returning the staff member to contact with individuals prior to the completion of the OSI investigation. **Compliance:** Substantial. **Current recommendation**: Conform facility practice regarding removing alleged staff perpetrators in A/N/E investigations to the procedure in SO 263.

2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	**Methodology:** Interviewed: 1. Donna Nelson, Standards Compliance Director 2. D. Karas, Program Director Reviewed: 1. WRPs of 20 individuals on high risk lists 2. WRPs of 26 individuals who have reached triggers 3. WRPs of nine individuals who were reviewed in second- and third-level risk management committees 4. Quality Council meeting minutes for the review period 5. Violence Risk Management Committee report Observed: Facility Review Committee meeting
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Substantial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice with self-monitoring. **Findings:** The facility is committing considerable resources to the collection of data on violence, the analysis of this data and the development of initiatives aimed at improving the safety of individuals in the facility. Peer-to-peer altercation data compiled by the facility shows an increase in incidents this

review period over last:

	Sep 2009-Feb 2010	March-August2010
Peer-to-peer altercations	357	418
Individuals involved in peer-to-peer altercations	623	863

Other findings:
As indicated in this section of the report, the facility has and uses its technological capacity to capture data to identify high-risk situations and communicate this to the WRPTs of individuals at risk.

	Sep 2009-Feb 2010	March-August2010
Peer-to-peer aggression resulting in major injury	60	83
Aggression to staff resulting in major injury	44	65
Individuals with two or more aggressive acts in 7 days	110	195
Individuals with four or more aggressive acts in 30 days	24	58
Homicide threats	0	0

These data tie to the data presented in the key indicators.

Current recommendation:
Continue current practice and self-monitoring of the safety of individuals in care.

I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Ensure that the WRPs of persons on high-risk lists for medical conditions

address the condition with objectives and interventions.

Findings:
As shown in the table below, the WRPs of 70% of the 20 individuals sampled contained reference to and objectives and interventions directed at the medical risk factor. Follow-up activities were lacking in some instances.

	Issue	WRP documentation
RDB	5/18/10 met trigger 7.2 for three or more falls in 30 days	WRP dated 7/19/10 discussed four reported falls for the month of June and listed individual as at high fall risk. Open focus 6.26 for fall risk with nursing objectives and inter-venetions. Individual receiving Physical Therapy services to address underlying factors related to fall risk.
PPD	Met trigger 7.1 for fall with major injury	No evidence of fall risk or review of fall incident found in review of WRP documents dated 10/7, 9/1, or 8/5/10.
SCK	5/29/10 met trigger 7.1 for fall with major injury	WRP dated 6/2/10 discussed fall incident and Fall Risk Assessment ordered. No Physical Therapy, Occupational Therapy assessments ordered to determine underlying cause of fall, although limited gait and/or diminished environmental awareness was suspected.
WL	Met trigger 7.1 for fall with major injury	No evidence of fall risk or review of fall incident found in review of WRP documents dated 8/28, 7/30, and 10/7, 9/1, or 8/5/10.
JL	New diagnosis of	Database listed new diabetes

			diabetes	diagnosis on 7/08/10, but diabetes listed as diagnosis in initial Nutrition Assessment on 1/19/10. The 10/08/10 WRP has DM listed on Axis III; focus 6.1 objectives and intervention in place for diabetes management by nursing staff. Individual is identified as at high nutritional risk and seen quarterly for Nutrition Assessment update. Most recent Nutrition Assessment (7/26/10) addressed DM and recommended enrollment in DM group.	
		DH	New diagnosis of diabetes	The WRP dated 10/04/10 listed DM on Axis III; focus 6.15 objectives and interventions in place to address DM by nursing and dietitian. Dietitian referral made following new diagnosis. Individual currently is being assessed monthly in accordance with an acuity level of IV.	
		RCM	Decubitus ulcer stage II on bilateral hips noted 3/11/10	WRP dated 7/29/10 described location, staging of decubiti and listed individual at high risk for impaired skin integrity. Focus 6.13 was opened to address pressure, with supports including an air mattress, and on 7/29 problem was closed due to healing. High risk referral made for nutrition assessment on 3/9/10 due to possible nutritional factors (i.e. weight loss and poor intake) which may have been contributing to skin ulcerations	

				and/or preventing optimal healing. He continues to be assessed as acuity level 3 (quarterly), and most current nutrition assessment dated 9/28/10 with primary nutrition diagnosis related to intake, including potential for compromised skin integrity. However, it appears that individual would have benefitted from a referral for OT and/or PT assessment to determine if or what optimal supports should be implemented to heal decubitus and prevent future recurrence.
		ACR	Chronic and diabetic ulcer/ cellulitis on foot- no date of onset found	WRP dated 9/8/10 had open focus 6.7 diabetic foot ulcer with objectives and interventions in place for caring for foot ulcer but not for learning how to prevent future recurrence (e.g., performing skin checks). Currently has egg crate mattress and diabetic healing boots and socks, egg crate for wheelchair. Nutrition assessment dated 9/30/10 addressed nutritional factors related to diabetes and diabetic ulcers; he is followed monthly as an acuity level IV.
		ELS	Decubitus ulcer on left hip- no date of onset found	WRPs dated 10/01/10, 9/01/10, 8/05/10, and 6/02/10 listed problem but did not list individual as at high risk for compromised skin integrity. Individual has open focus 6.21 to address skin breakdown prevention.

				Individual was enrolled in PT treatment to address low back pain, range of motion, and postural deficits but skin breakdown prevention (e.g., positioning, equipment) or wound healing issues not addressed in PT assessment 4/28/10 or subsequent progress notes.
		RD	Diagnosis of aspiration pneumonia 7/16/10	WRP dated 9/8/10 listed aspiration pneumonia incident and open focus 6.24 with objectives and interventions related to decreasing choking risk by naming ways to prevent choking. Individual has been followed monthly by the speech therapist due to dysphagia diagnosis since 2009, but no evidence of an individualized 24 hour plan was found.
		SRC	At high risk for metabolic syndrome	Dietitian referral was made 9/30/10 due to change in status (increase in lipids), which increased his nutritional risk acuity level. He is now being seen quarterly for Nutrition Assessment rather than every six months to address contributing risk factors of obesity and hyperlipidemia. Most recent WRP (10/06/10) does not list high risk for metabolic syndrome under risk factors.
		JAD	At high risk for metabolic syndrome	Dietitian assessment dated 7/20/10 mentioned contributing risk factors of obesity and hyperlipidemia but stated that individual refused

				interview, nutrition education, and dietary interventions to manage risk. High risk identified in the present status of the most recent WRP (9/20/10); open foci 6.6 for elevated BMI and 6.9 for hyperlipidemia.	
		RE	At high risk for metabolic syndrome	High risk identified in the present status of the most recent WRP (10/16/10). Open focus 6.3 for elevated BMI with objective and interventions by nursing, RT, and referral to Dietitian as needed.	
		DBL	At high risk for falls	High risk identified in the present status of the most recent WRP dated 10/6/10. Open focus 6.1 for safety measures related to atrophy in leg due to polio aimed at verbalizing safe mobility skills rather than practicing safe mobility. Individual referred for OT treatment for improved functional mobility but refused treatment; no evidence of recent referrals to OT or PT was noted.	
		JJS	At high risk for falls	High risk identified in the present status of the most recent WRP dated 10/13/10. No open focus for treatment of issue of fall risk and underlying factors. No evidence of referrals to OT or PT to assess mobility and physical component of fall risk was noted.	
		GAB	At high risk for impaired skin	High risk identified in the present status of the most recent WRP dated	

			integrity	10/06/10; no open focus to address risk.
		HLG	At high risk for impaired skin integrity	High risk not identified in the present status of the most recent WRP dated 9/27/10.
		MDH	At high risk for choking and aspiration	High risk not identified in the present status of the most recent (initial) WRP dated 10/13/10, but dysphagia is listed as an open focus 6.5 in WRP attachment dated 10/15/10, with 6.5 nursing objective and intervention in place to address risk. No order for Speech Therapy evaluation was found in the record due to identification of high risk secondary to dysphagia.
		ACW	At high risk for choking	High risk identified in the present status of the most recent WRP (9/30/10), with 6.1 nursing and dietitian objectives and interventions in place to address risk.
		GP	At high risk for choking and aspiration	High risk identified in the present status of the most recent WRP dated 10/20/10, but no open focus to address risk. The present status section of the WRP states that GP eats a modified diet with 1:1 supervision, but did not list a rationale for the reason, or a concomitant objective to attempt to move toward a less restrictive support.

		Current recommendation: Continue current practice and monitoring.
I.2.a. iii	identification of systemic trends and patterns of high risk situations.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue to produce the Violence Risk Management Committee Progress Report as a springboard for violence reduction initiatives. **Findings:** The facility issued the six-month report in October. Some of the findings are reported in I.2.c, particularly the influence of the high number of admissions in May and June of individuals who are deemed not competent to stand trial. This issue was specifically studied in a small study in April and May and the results were discussed at the June 1 Quality Council meeting. As follow-up to the facility's findings related to aggression and violence, the facility has undertaken several initiatives. • The facility reassembled the TMET team (a psychologist and two psych techs) to provide training and hands-on consultation to the units most impacted and any that requested their assistance. • The Hard-to-Throw chairs were discovered to have long screws that could be worked loose. All chairs were inventoried for loose screws and continuing monitoring of the chairs was made a responsibility of the Unit Supervisors. • Plans for a secure unit at ASH for individuals who are at exceptionally high risk for violence are included in the DMH five-year plan. This unit would provide enriched security staffing and increased structure. • The Peaceful Resolutions Committee continues to meet twice a month. It brought forward discussion of the lag between the awarding of the violence prevention incentive funds and the ability to use the funds for prized activities. In response, ASH presented a plan for speedier

		reinforcement. Specifically, once a month a Peace Bingo Night would be scheduled for any unit that has met criteria (three or fewer aggressive SIRs). Door entry prizes were given to everyone and prizes to bingo winners. • The facility has enhanced the Supplemental Activity program with stamp club, Spanish Activity night, special events, evening library hours, and seven activities between 7 and 8 PM. • A proposal has just been approved that will identify individuals who will assist cognitively challenged peers in a 1:1 setting. The mentor accompanies his peer to a designated mMall group to help the peer understand the concepts taught. • The initiation of the "Talk It Out" course by the DCAT team. **Current recommendation**: Continue current practice.
I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	**Compliance:** Substantial.
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** The facility is implementing the Risk Management Special Order, which identifies a hierarchy of interventions that correspond to triggers and thresholds as demonstrated in the cells below. **Current recommendation**: Continue current practice.

<table>
<tr>
<td>I.2.b.ii</td>
<td>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue developing initiatives to reduce violence at the facility.

Findings:
See I.2.a.iii for facility initiatives to reduce aggression.

Other findings:
See also I.1.c for ASH's work in studying falls and the realignment of partitions and beds to ensure that individuals under 1:1 observation while in bed can be observed by staff.

Current recommendation:
Continue current practice and monitoring.</td>
</tr>
<tr>
<td>I.2.b.iii</td>
<td>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue current practice.

Findings:
As shown in the table below, WRPTs had been notified of triggers and had cited the trigger in the individual's WRP for all of the triggers sampled.

<table>
<tr><th>Individual</th><th>Trigger type</th><th>Date</th><th>WRP Reference</th></tr>
<tr><td>AA</td><td>High PRN use</td><td>6/12
6/20</td><td>Cited in 10/11 WRP</td></tr>
<tr><td></td><td>Restraint >4 hrs.</td><td>6/11</td><td>Cited in 10/11 WRP</td></tr>
<tr><td>RB</td><td>Self harm</td><td>4/9</td><td>Cited in 10/18 WRP</td></tr>
<tr><td></td><td>High PRN use</td><td>3/20</td><td>Cited in 10/18 WRP</td></tr>
<tr><td>BM</td><td>1:1 observation</td><td>9/23
10/3</td><td>Cited in 9/17 WRP</td></tr>
</table>
</td>
</tr>
</table>

		<table><tr><td></td><td>High PRN use</td><td>8/17</td><td>Cited in 9/17WRP</td></tr><tr><td></td><td>Restraint >4 hrs</td><td>8/15</td><td>Cited in 9/17WRP</td></tr><tr><td></td><td>2or+ agg. acts to others in 7 days</td><td>8/16</td><td>Cited in 9/17WRP</td></tr><tr><td>TG</td><td>1:1 observation</td><td>2/11</td><td>Cited in 8/30 WRP</td></tr><tr><td>RCH</td><td>Seclusion > 4 hrs</td><td>6/3 6/6</td><td>Cited in 6/22 WRP</td></tr><tr><td>JW</td><td>2or+ agg. acts to others in 7 days</td><td>6/23 6/26</td><td>Cited in 7/20 WRP</td></tr></table> **Current recommendation**: Continue current practice.
I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendation:** **Recommendation, April 2010:** Remind WRPTs of the need to reference incidents and develop objectives and interventions when warranted. **Findings:** As shown in the tables in this section, in the samples reviewed, ASH is successful in addressing high risk status, triggers and most recommendations made in Risk Management Committees in the WRPs of the individuals involved. **Current recommendation**: Continue current practice.
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice including self-monitoring.

Findings:
See table below which demonstrates that the WRPs of all individuals in the High Risk List sample, with the exception of those on the victimization list, cited the risk factor and addressed it with a treatment objective and interventions.

Other findings:

Individual	High Risk Category	Listed in Risk Factors?	Addressed in WRP?
RB	Falls	Yes	WRP 9/16 Focus 6.26 related to leg weakness
VK	Falls	Yes	WRP 9/22 No objective
CB	Falls	Yes	WRP 9/16 Focus 6.22 secondary to sleep apnea
RR	Falls	Yes	WRP 9/13 Focus 6.14 secondary to visual impairment
AA	Aggression	Yes	WRP 9/17 Focus 3.1
BB	Aggression	Yes	WRP 9/21 Focus 3.6 includes BGs
RG	Aggression	Yes	WRP 9/30 Focus 3.2
ML	Aggression	Yes	WRP 10/14 Focus 3.1
CJ	Aggression	Yes	WRP 10/21 Focus 3.1

BM	Aggression	Yes	WRP 9/17 No objective
RE	Aggression	Yes	WRP 9/14 No objective
LM	Aggression	Yes	WRP 9/28 Focus 3.1
AA	Aggression to Self	Yes	WRP 10/11 Focus 3.1
RB	Aggression to Self	Yes	WRP 10/18 Focus 3.3
RD	Aggression to Self	Yes	WRP 9/27 Focus 3.2
BM	Aggression to Self	Yes	WRP 9/17 Focus 3.5
SC	Suicide	Yes	WRP 9/22 Focus 3.1
TG	Suicide	Yes	WRP 8/30 Focus 1.1
BG	Victimization	Yes	WRP 9/7 No objective
ZW	Victimization	No	WRP 10/6 No objective WRP 2/11 No objective

Review of follow-up by WRPTs of recommendations made in second and third level risk management meetings yielded the following findings:

Individual	Committee Date	Recommendation	Follow-up

RE	FRC 8/18/10	F/u with family to determine education level.	Communicated with mother and learned required information.
PL	ETRC 6/2/10	Verify diagnosis	Diagnosis subsequently changed.
RCH	ETRC 6/2/10	Adjust meds	Medications adjusted.
LB	ETRC 6/2/10	Rule in or rule out vascular dementia diagnosis	No evidence of response in 6/15/10 WRP.
OC	ETRC 6/2/10	Clarify diagnosis and revisit justification for use of Prozac	WRPs 7/6 & 9/2 continue to state OC remains on Prozac, but this medication is not in listing of medications.
KH	ETRC 6/23/10	Address hypo-thyroidism (misstated as hyper)	WRP 7/16 states TSH levels drawn and results documented.
RB	ETRC 6/23/10	Get neurology Consult	WRP 7/19 states individual is being followed by neurology.
PN	ETRC 6/16/10	Focus on reducing side effects of medication.	WRP 6/22/10 shows medications changed and fewer of the problematic side effect
JW	ETRC 6/30/10	F/u with neurology referral	WRPs on 7/5 & 7/20 make no mention of the recommendation or action taken to implement it.

		As shown in the table above, 6 of 9 observable recommendations made at second and third level Risk Management Committees were noted or documented as implemented in the individual's WRP. **Current recommendations**: 1. Continue current practice as related to WRP address of high risk conditions. 2. Clarify expectations around WRP response to recommendations made at Risk Management meetings.
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current efforts to reduce violence and implement initiatives presently under consideration if, and when, determined appropriate. **Findings:** The facility has continued to do exemplary work in identifying factors that contribute to violence. This work was compiled most recently in the report to the Quality Council from the Violence Risk Management Committee presented in October 2010. Findings include the following: • Upon recognizing that the use of restraint and seclusion rose in April, further study found that six individuals were responsible for most of the increase. Four of the six individuals had been placed together in the same unit. The men were reassigned to separate units. • Violence is most often seen in individuals in the first 90 days of admission. • An increase in violence in May and June to the highest rates in the period September 2008-August 2010 coincided with the influx of admissions of individuals deemed incompetent to stand trial. The rates seen in July and August have subsequently decreased. • In response to the substantial increase of admissions in June of

		individuals deemed incompetent to stand trial and the anticipated increase in violence, the facility enhanced nursing coverage and support by PBS and DCAT on key units and added two admissions teams to process the individuals. Additionally, meetings were held with the individuals on the units to advise them that many new admissions would be coming in shortly. • The facility moved the 2684 Program (for men from prison) to all dormitory units as distinct from single bedrooms to assist in suicide prevention. **Compliance:** Substantial. **Current recommendation**: Continue current practice including the study of violence and efforts directed at reducing violence.

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: 1. E. Dawson, Assistant Hospital Administrator 2. L. Euler, Chief of Plant Operations 3. S. Everett, Health and Safety Officer These staff members and supervisory unit staff led the environmental tour, offered information, and answered questions. Reviewed: 1. WRPs of 10 individuals with the problem of incontinence 2. Temperature monitoring data 3. WRPs of eight individuals involved in sexual incidents Toured: Four units: 33, 34, 22, 23 and main courtyard kiosk
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendation:** **Recommendation, April 2010:** As planned, make adjustments to the clothing pass-through in the shower room on Unit 30 and continue the bathroom vent and partition project. **Findings:** ASH has replaced the clothing pass-throughs that had metal horizontal bars and a plexiglass window with a small pass-through opening. The facility reports that the bathroom refurbishing is 75% complete. The tall upright stall partitions have been removed, the partitions strengthened, piano hinges installed, and gaps between stalls and the wall have been eliminated. The towel and clothes holders in the shower area have no protruding material and could not be used for self-harm. Louver vents directly over fixtures in

		bathrooms were replaced with fine mesh screens. These improvements were observed in the units toured. The facility reported that during the review period, an average of 183 items addressing suicide prevention in the environment were inspected and completed each month. The facility reports there have been no suicides or serious suicide attempts since April 2010. ASH further reported that the number of aggressive acts to self has remained fairly constant over the review period. The number ranged from a low of 28 in July to 37 in March. Four months clustered around the mean of 33. **Other findings:** Additional observations made during the unit tours include the following: • Each unit had a cut-down instrument in a plastic container mounted on the wall of the med room. Thus all staff, regardless of where they may be floated, should be able to get the instrument quickly when needed. • All units visited had working flashlights with which to make nighttime rounds. • Individuals use the nightstands to store food and used beverage and food containers. It appears that cleaning these is not yet part of the weekly unit clean-up. • The common areas visited were clean and many were decorated in autumn and/or Halloween themes. • To increase safety and visibility of all dorm beds in the 258 bed addition, the two beds on the far side of the partitions were moved against the far wall. This allows for all dorm beds/individuals to be seen in their entirety from the hall windows prior to entering the dorms. • The tour was conducted shortly after individuals who have jobs received their monthly pay. One individual whose room was toured on Unit 33 had a brown paper grocery bag filled with donuts—at least five dozen--

		creating a temptation to over-indulge. One can see how this could also present have/have-not conflicts. **Compliance:** Substantial. **Current recommendations**: 1. Investigate the possibility of paying individuals who have a job more frequently to reduce individuals' need to spend quickly and hoard large quantities of snacks. 2. Add cleaning of the nightstands to the standard bedroom clean-up routine.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** The facility reported that 77 units and areas have been monitoring temperatures daily. Individuals made no complaints about unit temperatures and the units were comfortable at the time they were toured. **Compliance:** Substantial. **Current recommendation**: Continue current practice and monitoring of unit temperatures.
I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	**Current findings on previous recommendation:** **Recommendation, April 2010:** Meet the care needs of any individual who may develop the problem of

incontinence.

Findings:
The facility reported the following data:

Criterion	Compliance rate
Incontinence status is addressed in Present Status	100%
Incontinence identified in Focus 6	100%
Objectives promote dignity and self-reliance	100%
Individual is clean, dry and odor-free	100%
Nursing staff explain how they assist the individual	100%

Other findings:
As shown below, the findings from the sample reviewed matched the facility's audit findings that WRPs addressed the problem of incontinence for all individuals sampled.

Individual	WRP Date	Focus 6
AG	9/16	6.6 Urinary Incontinence
CV	9/27	6.7 Incontinence
DS	10/12	6.18 Bowel & Bladder Incontinence
ES	9/23	6.2 Bowel & Bladder Incontinence
JR	10/6	6.16 Bowel & Bladder Incontinence
OP	9/14	6.6 Enuresis
PC	10/5	6.25 Enuresis
RC	10/5	6.16 Urinary Incontinence
RDC	9/3	6.9 Enuresis
RM	10/6	6.5 Enuresis

Compliance:
Substantial.

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<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>I.3.d</td><td>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</td><td>Current findings on previous recommendation:

Recommendation, April 2010:
Continue encouraging staff to document their efforts at counseling, assessing, and comforting as appropriate.

Findings:
The following is a summary of charts and incidents reviewed:

<table>
<tr><td>Individual
Incident date</td><td>Incident type</td><td>Response Documented in Clinical Record</td></tr>
<tr><td>JW
5/8/10</td><td>Consensual contact</td><td>Both individuals placed on sick call. Nursing assessment completed.</td></tr>
<tr><td>DK
5/19/10</td><td>Alleged aggressor-sexual assault</td><td>Denies involvement. Placed on psychiatric sick call. DPS notified.</td></tr>
<tr><td>FT
4/23/10</td><td>Consensual contact</td><td>Counseled about appropriate boundaries and ASH's view that sexual relationships divert attention from recovery as well as the physical health risks. As neither individual appeared receptive to this counseling, a staff member was positioned to prevent further contact and both were placed on medical and psychiatric sick call.</td></tr>
<tr><td>PH</td><td>Alleged aggressor-</td><td>DPS notified and a report</td></tr>
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		4/21/10	Unwanted sexual contact	taken. No further information in IDN. [**See note below]
		AM 4/6/10 6/8/10	Alleged victim- Unwanted sexual contact	Aggressor was redirected and counseled. Unit physician notified in April incident. June incident involves same aggressor. AM told to report problems immediately. Men separated on different ends of hall. Aggressor put on q 15 minute observation and placed on psychiatric sick call.
		RB 3/11/10	Alleged victim- Sexual assault	DPS, NOD and POD notified. Separated onto different hallways initially, later transferred to another unit. Seen by psychiatrist the next day and by psychologist on 3/15.
		JR 4/3/10	Alleged aggressor Sexual assault	DPS, MOD and POD notified. Counseled to leave victim alone.
		RR 4/3/10	Alleged victim Sexual assault	Victim said aggressor (JR) has been bothering him for weeks, offering snacks for sex. DPS took a report. MOD advised. [**See note below]
		** Note: In both of these incidents, the SIR reviews indicate that the individual was counseled and offered other services. However, this and other relevant information is not documented in the IDN describing the incident. In the incident involving PH on 4/21/10, the SIR states PH was counseled regarding boundaries and informed his behavior was disrespectful. The SIR further states that relevant portions of Administrative Directives		

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<td>were reviewed with him. The psychiatrist recommended that he be returned to prison and he was sent back.

In the April incident involving RR, the SIR states that the aggressor denied the assault. RR refused a physical exam but accepted prophylactic medication. It further states that he was offered counseling by nursing staff and the unit psychologist. The incident was reviewed in PRC on 4/8/10 with the recommendation that closer observation of the main bathroom be initiated.

Compliance:
Substantial.

Current recommendation:
Reinforce the standard procedure that all services provided as a result of a sexual or other incident be documented in the individual's record.</td>
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<tr>
<td>I.3.e</td>
<td>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</td>
<td>Current findings on previous recommendation:

Recommendation, April 2010:
Provide current data at the next monitoring visit.

Findings:
The facility reported that all non-clinical mall providers are current in meeting their training obligations:

<table>
<tr><th>Course</th><th>Compliance rate</th></tr>
<tr><td>TSI-1 (q 2 years)</td><td>100%</td></tr>
<tr><td>Abuse and Neglect (annual)</td><td>100%</td></tr>
<tr><td>By Choice (one time)</td><td>100%</td></tr>
<tr><td>Mall Overview (one time)</td><td>100%</td></tr>
<tr><td>Group Facilitator (one time)</td><td>100%</td></tr>
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		Learning Strategies (one time) 100% Mean Compliance Rate 100% **Compliance:** Substantial. **Current recommendation**: Continue current practice.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. The leadership of the Hospital Advisory Committee continues to meet to discuss in an organized fashion issues that affect their lives, limiting discussion, to the degree possible, to systemic rather than individual-specific issues. Their attention is particularly directed at making ASH a safe environment. They acknowledged the efforts made by the hospital leadership to meet this goal and, as cited below, made suggestions independently designed to foster positive interpersonal relationships. 2. The representative from the Peaceful Resolution Committee explained the plans for the second Season of Peace, which will run from January-March. It will include performances by the eight-man ASH chorus.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: 1. Several individuals while touring units 2. Brooke Hatcher, HAC facilitator (informal interview) <u>Reviewed</u>: Individuals' survey data <u>Participated</u>: Hospital Advisory Council Leadership meeting
J		**Current findings on previous recommendation:** **Recommendation, April 2010:** Continue current practice. **Findings:** At the HAC Leadership meeting, individuals expressed appreciation for the

		increased recreational opportunities on evenings and weekends and for the new exercise equipment in the courtyard. Individuals linked these activities to a higher quality of life and a reduction in aggression. They expressed the hope that with the passage of the state budget, there would be funds to replace or repair the broken exercise equipment in the gym. Two additional requests were made to be brought forward to the administration: first, the need to ensure that when groups are cancelled, this is not recorded as non-attendance, thereby reducing an individual's attendance rate as reflected in his WRP; and second, the need for consistent application of the level system across units within a Program and across Programs. Individuals made two suggestions which they believed had the potential to have a positive impact in reducing aggression. The first was the creation of a position in each unit for an individual to act as a "greeter." This individual would welcome new individuals to the unit and "show them the ropes." The addition to the Mall schedule of a group entitled "Human Relations" is the second suggestion. This group would provide diversity training, instilling an appreciation of the many cultures represented in the hospital population. If a separate group were not possible, the suggestion was made to add this component to the WRAP groups. **Other findings:** As cited below, responses to the survey remained very similar to those in the last reporting period. The greatest degree of negative response was directed at the Protection and Advocacy grievance procedures. Six of the seven questions directly related to the facility received positive responses that hovered around 90%. The lower rate of positive responses to the question regarding free communication raises concern; however, this issue was not raised by individuals during the HAC meeting when other concerns were discussed.

	Percentage of positive responses	
Item	9/09-2/10	3/10-8/10
Feel safe?	84%	88%
Treated with respect?	95%	91%
Environment clean and safe?	89%	89%
Helped to meet W&R goals?	90%	89%
Your rights have been explained to you?	86%	88%
Grievance process works?	72%	72%
If you see A/N, can you report it?	92%	88%
Able to communicate freely with family, attorney or advocate?	84%	82%

Compliance:
Substantial.

Current recommendation:
Continue current practice whereby individuals bring systemic concerns forward to administration through the HAC proposal procedures.